Supreme Court, U.S.
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No. 06-415

In The
Supreme Court of the United States

JOHN SELIG in his official capacity as Director of the ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES; RAY HANLEY in his individual capacity as former Director of the DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES; and ROY JEFFUS, in his individual capacity and his official capacity as Director of the DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioners,

vs.

PEDIATRIC SPECIALTY CARE, INC; CHILD AND YOUTH PEDIATRIC DAY CLINICS, INC; FAMILY COUNSELING AND DIAGNOSTIC CLINIC; TOMORROW'S CHILD LEARNING CENTER LLC; D AND D FAMILY ENTERPRISES, INC.; JAMES SWINDLE and STACEY SWINDLE as parents and next best friends of JACOB and NOAH SWINDLE, minors; SUSANN CRESPINO, as parent and next best friend of MICHAEL CRESPINO,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. PRIVATE ENFORCEMENT: Does the statute defining the services that state Medicaid programs are authorized to cover create private rights that are enforceable under 42 U.S.C. § 1983? Does the statute that obligates states to safeguard against unnecessary Medicaid utilization create private rights that are enforceable under 42 U.S.C. § 1983?

2. QUALIFIED IMMUNITY: Are state Medicaid directors subject to personal monetary liability under Section 1983 for:

(a) Medical necessity decisions made by independent board-certified physicians engaged (but not employed) by a federally designated independent contractor of the state Medicaid program; or

(b) Unauthorized conduct of a nurse employed by the federally designated independent contractor?

PARTIES TO THE PROCEEDINGS

Petitioners Arkansas Department of Health and Human Services; John Selig in his official capacity as Director of the Arkansas Department of Health and Human Services; Ray Hanley in his individual capacity as former Director of the Division of Medical Services of the Arkansas Department of Health and Human Services; and Roy Jeffus, in his individual capacity and his official capacity as Director of the Division of Medical Services of the Arkansas Department of Health and Human Services were defendants in the trial court and appellants in the United States Court of Appeals for the Eighth Circuit.

The plaintiffs and appellees below are Pediatric Specialty Care, Inc.; Child and Youth Pediatric Day Clinics, Inc.; Family Counseling and Diagnostic Clinic; Tomorrow's Child Learning Center LLC; D and D Family Enterprises, Inc. (Medicaid certified providers of Child Health Management Services ("CHMS")); James Swindle and Stacy Swindle as parents and next best friends of Jacob and Noah Swindle; and Susann Crespino as parent and next best friend of Michael Crespino. Jacob and Noah Swindle and Michael Crespino were eligible for CHMS in 2001 when the plaintiffs filed the original complaint, but it is undisputed that they were ineligible for any CHMS services by the time the petitioners filed the summary judgment motion that led to this petition.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit filed on April 17, 2006, is published at 443 F.3d 1005 (2006) and is reproduced in the Appendix at App. 1. The opinion and judgment of the United States District Court for the Eastern District of Arkansas filed on February 7, 2005, is unpublished and is reproduced in the Appendix at App. 26.

JURISDICTION

The judgment of the United States Court of Appeals for the Eighth Circuit was entered on April 17, 2006. App. 1-22. The Eighth Circuit denied petitioners' timely motion for rehearing or rehearing en banc on June 22, 2006. App. 74. Jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS"), administers grants to states for medical assistance programs ("Medicaid"). Medicaid was enacted to enable "each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396.

> Congress created the Medicaid program in 1965 by adding Title XIX to the Social Security Act. The program authorizes federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons. In

> order to participate in the Medicaid program, a State must have a plan for medical assistance approved by the Secretary of Health and Human Services (Secretary). 42 U.S.C. § 1396a(b). A state plan defines the categories of individuals eligible for benefits and the specific kinds of medical services that are covered. §§ 1396a(a)(10), (17).

Pharm. Research & Mfrs. Ass'n v. Walsh, 538 U.S. 644, 650 (2003) (footnotes omitted). 42 U.S.C. § 1396a(a) begins by declaring that "[a] State plan for medical assistance must" provide for sixty-five enumerated requirements. The Health and Human Services Secretary ("Secretary") "shall approve any plan which fulfills the conditions in subsection (a). . . ." 42 U.S.C. § 1396a(b). If the state plan does not comply with the Medicaid Act, or if the state is operating the program in noncompliance with the state plan:

> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure.).

42 U.S.C. § 1396c.

The plaintiffs seek damages and injunctive relief under 42 U.S.C. § 1396a(a)(30)(A), which requires state plans to:

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization

> of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

The plaintiffs also seek damages and injunctive relief under 42 U.S.C. § 1396d(a)(13), which provides:

> (a) For purposes of this title the term "medical assistance" means payment of part or all of the cost of the following care and services . . .
>
> (13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

INTRODUCTION

Child Health Management Services

On December 6, 2001, the plaintiffs filed a complaint challenging plans made by the Arkansas Medicaid Program to amend the Arkansas State Medicaid Plan by deleting certain Plan provisions regarding the Child Health Management Services ("CHMS") program.[1] On January 6, 2003, the plaintiffs filed the first in a succession of amended complaints adding challenges to CHMS

[1] Arkansas has the only state Medicaid program that includes CHMS in its State Medicaid plan.

medical necessity determinations.[2] The plaintiffs filed the fifth and most recent amended complaint on July 7, 2004.

CHMS facilities are licensed day care centers that are intended to serve children with specialized physical, developmental, behavioral or emotional needs. CHMS services include diagnostic and evaluation services, day treatment, therapies and other treatments. *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472, 475 (8th Cir. 2002). After a physician referral, CHMS clinic staff, including nurses, social workers, therapists, and psychologists, perform a diagnostic evaluation consisting of audiology, medical, behavioral, speech, language, and psychological assessments. Using the results of these evaluations, a CHMS physician prepares an individual treatment plan and prescribes services and treatments for the child. *Id.* at 475-76.

Day treatment, often referred to as classroom service, is the CHMS service that is disputed in this case. Day treatment is a form of day care in which classroom teachers reinforce therapies such as speech therapy, occupational therapy, and physical therapy. *Id.* at 472 n.2. Often this occurs in the same day care room occupied by children who are not eligible for CHMS and are receiving only regular day care.

The plaintiffs allege that the issue is the amount of CHMS day treatment that AFMC determines to be medically necessary. However, the more basic question is whether there is a private statutory right entitling the plaintiffs to litigate that issue under § 1983. The state's position is that no federal statute creates any right to receive Medicaid services that are not medically necessary

[2] The present system of CHMS utilization review predated the original complaint.

as determined by AFMC's independent board-certified physicians.

The plaintiffs seek declaratory and injunctive relief dictating a minimum amount of CHMS care that each independent reviewing physician must in the future determine to be medically necessary. The plaintiffs also seek to make state Medicaid directors personally liable to pay for care that is not necessary in the independent physicians' professional judgments.

Medical Necessity

Legally, Medicaid may reimburse only medically necessary covered services. *See* 42 U.S.C. § 1396 (Medicaid is established for the purpose of providing "necessary medical services."); 42 U.S.C. § 1320a-7 (providers furnishing unnecessary services shall be excluded from Medicare and Medicaid); 42 U.S.C. § 1320c-5 (health care services provided under the Social Security Act must "be provided economically and only when, and to the extent, medically necessary.") It is consistent with Medicaid objectives "for a State to refuse to fund *unnecessary* – though perhaps desirable – medical services." *Beal v. Doe*, 432 U.S. 438, 444-45 (1977) (emphasis in original).

To prevent Medicaid from paying for unnecessary services, 42 U.S.C. § 1396a(a)(30)(A) requires states to maintain "methods and procedures" to "safeguard against unnecessary utilization" of Medicaid care and services. *See also* 42 C.F.R. § 456.3 (states must have utilization control programs limiting care based on criteria such as medical necessity).

Peer Review of Medical Necessity

In 1972, Congress was alarmed that Medicare and Medicaid costs were rising rapidly despite laws prohibiting unnecessary care and requiring utilization reviews. Accordingly, Congress enacted significant changes to Medicare and Medicaid utilization controls, and created peer review organizations.

Peer review is designed to have physicians "judge whether services ordered by other physicians are necessary." S. REP. 92-1230, at 256 (1972). Peer review organizations are "primarily responsible for review of all [M]edicare and [M]edicaid services rendered or ordered by physicians." *Id.* at 262. Congress intends that peer review organizations "evaluate the appropriateness of medical determinations so that Medicare and Medicaid payments will be made only for medically necessary services. . . . " *Id.* at 261-62.

Federally designated utilization and quality control peer review organizations are defined in 42 U.S.C. § 1320c-1 and referred to informally as "QIOs." Under 42 U.S.C. § 1395y(g), the Secretary must contract with QIOs to determine medical necessity. Federal QIOs are then subject to monitoring and evaluation by the Secretary, who may terminate, or refuse to renew, any QIO certification and contract. *See generally* 42 U.S.C. § 1320c-2(b)(3). As a matter of law states satisfy their Medicaid utilization control obligations by contracting with a federal QIO to make medical necessity determinations. 42 U.S.C. § 1396a(d); 42 C.F.R. §§ 431.630, 456.2. Arkansas Medicaid contracts with AFMC, the federally designated QIO in Arkansas, to perform medical necessity reviews in the CHMS program.

Prior Authorization

Arkansas Medicaid rules require prior authorization for CHMS day treatment services. As the name implies, prior

authorization is a process by which the medical necessity of care is approved or disapproved before the care is provided. AFMC nurses review CHMS prior authorization requests. If the nurse concludes that *all* the care is necessary AFMC issues a prior authorization. Otherwise, the request is referred to a board-certified pediatrician who issues a medical necessity determination. App. 6.

Prior Authorization Review and Appeal

42 U.S.C. § 1320c-3(a)(3)(A) provides for reconsideration by a second board-certified pediatrician if the first pediatrician denies the request in whole or in part. All decisions denying some or all of a request are subject to administrative appeal. 42 U.S.C. § 1396a(a)(3); ARK. CODE ANN. § 25-15-208. Administrative appeals are subject to judicial review. ARK. CODE ANN. § 25-15-212. Judicial review includes appellate review. *See, e.g., Williams v. Scott,* 278 Ark. 453 (1983). Despite these remedies expressly provided by Congress, the plaintiffs want the federal courts to superintend individual medical necessity determinations.

STATEMENT OF THE CASE

This litigation has a long history.[3] The issues relevant to this petition arose when the plaintiffs amended the complaint to allege that AFMC prior authorization decisions denied CHMS care that should have been approved as medically necessary, and that such denials violated 42 U.S.C.

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[3] *See Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472 (8th Cir. 2002); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 364 F.3d 925 (8th Cir. 2004); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, App. 1-22, reported at 443 F.3d 1005 (8th Cir. 2006), and *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 444 F.3d 991 (8th Cir. 2006).

§§ 1396a(a)(30)(A) and 1396d(a)(13). The plaintiffs sued Ray Hanley, the Arkansas Medicaid Director, in his individual capacity seeking money damages measured by subtracting the cost of day care that AFMC approved as medically necessary from the amount that the plaintiffs contend should have been approved. Hanley subsequently resigned and was succeeded by Roy Jeffus. The plaintiffs then amended the complaint to seek damages from Jeffus also.

Petitioners moved for summary judgment. The district court denied the motion. The petitioners appealed to the Eighth Circuit, which held that 42 U.S.C. §§ 1396a(a)(30)(A) and § 1396d(a)(13) are privately enforceable under § 1983 by Medicaid providers acting for themselves and for unnamed Medicaid recipients. The circuit court also held that neither Jeffus nor Hanley is entitled to qualified immunity from suit for the cost of care that was unnecessary according to independent physicians engaged by AFMC.

REASONS FOR GRANTING THE WRIT

I. THE COURT BELOW FAILED TO APPLY THE STANDARD CONFIRMED AND CLARIFIED IN *GONZAGA UNIVERSITY v. DOE* THAT A PLAINTIFF HAS A "RIGHT, PRIVILEGE OR IMMUNITY" ENFORCEABLE UNDER SECTION 1983 ONLY IF CONGRESS UNAMBIGUOUSLY INTENDED TO CONFER AN INDIVIDUAL RIGHT TO ENFORCE A REQUIREMENT OF FEDERAL LAW.

(a) 42 U.S.C. § 1396a(a)(30)(A) (Utilization Controls) Historical Splits among the Circuit Courts of Appeal

Before *Gonzaga University v. Doe*, 536 U.S. 273 (2002), the circuits were split on the question of whether § 1396a(a)(30(A) provides Medicaid recipients, providers,

or both, with a right enforceable under 42 U.S.C. § 1983. The Fifth and Eighth Circuits held that Medicaid recipients had enforceable rights. *See Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 927-28 (5th Cir. 2000); *Ark. Med. Soc., Inc. v. Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993). In dicta, the Third Circuit supposed that recipients had enforceable rights but providers did not. *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 543-44 (3d Cir. 2002) (*en banc*). The First Circuit held that there is an enforceable right for providers and in dicta supposed that recipients might have enforceable rights also. *Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen*, 93 F.3d 997, 1004 n.7 (1st Cir. 1996). The First, Seventh, and Eighth Circuits held that Medicaid providers have a private right of action. *See id.*, 93 F.3d at 1005; *Methodist Hosps., Inc v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996); *Ark. Med. Soc'y*, 6 F.3d at 528. However, the Third and Fifth Circuits held that providers have no enforceable rights under § 1396a(a)(30)(A). *Pa. Pharmacists Ass'n*, 283 F.3d at 543; *Walgreen Co. v. Hood*, 275 F.3d 475, 478 (5th Cir. 2001); *Evergreen Presbyterian Ministries, Inc.*, 235 F.3d at 929.[4]

The Decision Below Conflicts with *Gonzaga University v. Doe* and post-*Gonzaga* Decisions of Other Circuits

The decision below conflicts with *Gonzaga* and every circuit court of appeals decision ruling on the enforceability of § 1396a(a)(30)(A) since *Gonzaga*. *See Westside Mothers v. Olszewski*, 454 F.3d 532, 542 (6th Cir. 2006) (holding no private enforcement); *Long Term Care Pharmacy Alliance v.*

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[4] This summary is paraphrased from *Westside Mothers v. Olszewski*, 454 F.3d 532, 543 (6th Cir. 2006).

Ferguson, 362 F.3d 50, 59 (1st Cir. 2004) (holding no provider enforcement); *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005) (holding no individual rights created). Only the Eighth Circuit has refused to follow *Gonzaga*, which held that Congress confers enforceable rights only when it uses "rights-creating" language. 536 U.S. at 287.

Gonzaga also held that only unambiguously conferred rights, as distinguished from mere benefits or interests, are enforceable under 42 U.S.C. § 1983. *Id.* at 282-83. It is not enough that the plaintiff falls within the zone of interest that the statute is intended to protect or that the plaintiff benefits from the statute. *Id.* at 283-86. Rather, the statute must unmistakably focus on the benefited class, be phrased in terms of the persons benefited, and confer rights on those persons. *Id.* at 284-85. Similarly, it is not enough for a statute to speak in terms of institutional policy or practice; it must provide for individual rights without an aggregate focus. *Id.* at 288, 290.

After being fully informed regarding *Gonzaga* and relevant post-*Gonzaga* Medicaid precedents, the Eighth Circuit created a head-on conflict with these decisions by basing its ruling not on the presence or absence of rights-creating language, but rather on a benefits test. *See* App. 17. "To determine [the existence of an enforceable right], one must consider the *benefit* conferred by the statute, the intended beneficiary, and whether the statute provides for some type of enforcement action short of a private cause of action." *Id.* (emphasis added). This benefits test ignores the fact that rights-creating language must appear in the statute.

Similarly, the Eighth Circuit found that "[t]he intended beneficiaries [of 42 U.S.C. § 1396d(a)(13)] are the needy child and *by corollary*, those who incur costs in

providing those services." App. 18 (emphasis added). This statement contains two concepts that are especially troublesome. First, *Gonzaga* makes it unmistakably clear that privately enforceable rights cannot arise by inference. Second, the notion of a vicarious private cause of action is incompatible with the standing requirement stated in the United States Constitution, Article III, § 2 and explained in *Arizonans for Official English v. Arizona*, 520 U.S. 43, 64 (1997); *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992); and *Duke Power Co. v. Carolina Envtl. Study Group, Inc.*, 438 U.S. 59, 72 (1978).

More conclusive evidence that the Eighth Circuit applied the wrong test is found in the following two passages from the opinion. First, the court stated: "Similarly, 42 U.S.C. § 1396a(a)(30)(A), is intended to *benefit* both CHMS recipients and providers, and creates enforceable rights for both groups." App. 18 (emphasis added). The court also said: "The beneficiaries are both the recipients of the services and the recipients of the state's payment, who are the CHMS providers." App. 18-19. Thus, the circuit court inferred an enforceable right upon finding that the statute confers a benefit. However, the court was required to find *both* a benefit and rights-creating language. *Gonzaga*, 536 U.S. at 287. Congress chose not to include rights-creating language in the relevant provisions, so the circuit court understandably failed to point to any such language in its opinion.

The Eighth Circuit identified the benefit conferred by paraphrasing § 1396a(a)(30)(A), to mandate "equal access to quality care for needy children." App. 18. As to equal access and quality care, § 1396a(a)(30)(A) states:

> [a] state plan for medical assistance must – provide such methods and procedures relating to the . . . payment for, care and services available under the

> plan . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

This provision establishes: (1) general principles for Medicaid plan payment methods and procedures; and (2) criteria for the Secretary to use in judging the state plan payment principles. This is not rights-creating language. Moreover, the four Medicaid rate-setting principles – efficiency, economy, quality of care, and access – are institutional policies having a distinctly aggregate focus. *Gonzaga* expressly states that neither institutional policies nor policies having an aggregate focus create privately enforceable rights. *Gonzaga*, 536 U.S. at 288-90. In other words, private enforcement is available only under laws that establish individual rights. Laws that establish general rate-setting principles do not establish privately enforceable rights.

That said, this case challenges AFMC's medical necessity utilization control decisions, not Medicaid rate setting. Payment rates have nothing to do with AFMC's medical necessity determinations, so the provision relied upon by the Eighth Circuit is not relevant to this case.

Congress unambiguously declared that AFMC, as a QIO, is immune from liability for its medical necessity decisions. Thus, it is clear that Congress intended that QIO decisions *not* give rise to litigation. *See* 42 U.S.C. § 1320c-6(b):

> No organization having a contract with the Secretary under this part [42 U.S.C. §§ 1320-c through 1320c-12], and no person who is employed by, or who has a fiduciary relationship

> with, any such organization or who furnishes professional services to such organization, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this part or to a valid contract entered into under this part, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

Utilization Controls

Utilization controls are federally mandated. All Medicaid state plans must provide:

> such methods and procedures relating to the utilization of . . . care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4) [42 U.S.C. § 1396b(i)(4)]) as may be necessary to safeguard against unnecessary utilization of such care and services.

42 U.S.C. § 1396a(a)(30)(A). Arkansas Medicaid decided the best way to fulfill its obligation to establish CHMS medical necessity "methods and procedures" is to contract with AFMC to determine whether CHMS day care is medically necessary and if so, in what quantities.

Under the AFMC contract the utilization control "method" is QIO prior authorization of medical necessity. The QIO has established a two-part procedure. First, nurses review care requests. Any request that the nurse cannot approve is then referred to an independent board-certified practicing pediatrician. In addition to "methods and procedures," board certified pediatricians must apply:

> professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice within the geographic area served by the organization as principal points of evaluation and review, taking into consideration national norms where appropriate.

42 U.S.C. § 1320c-3(a)(6)(A). Upon request yet another independent AFMC physician considers those elements of the request that the first reviewing physician denied.

Utilization controls have only one purpose: limiting care and services to those that are medically necessary. Unnecessary care is not available under the State Plan, so there are no methods and procedures to set unnecessary care payments, assure the quality of unnecessary care, or assure access to unnecessary care. Certainly there is no clearly established federal right to unnecessary care or to demand and receive a favorable medical necessity determination. In short, federal law prohibits payment for unnecessary care under any State Medicaid Plan. 42 U.S.C. § 1396a(a)(30)(A).

If federally designated quality control peer review organizations such as AFMC are not allowed to function as Congress intended, then unnecessary costs will accumulate and Medicaid programs will be challenged financially. Medicaid will be unable to provide basic necessary healthcare for our most needy citizens.

There is No Private Cause of Action to Enforce Utilization Control Provisions

Even before *Gonzaga*, private enforceability of the utilization review component of 42 U.S.C. § 1396a(a)(30)(A) was considered and rejected. *Prestera Ctr. for Mental Health Servs., Inc. v. Lawton,* 111 F. Supp. 2d 768 (S.D.

W.Va. 2000). The plaintiff contended that the utilization control provisions confer a "right to require the state to follow duly promulgated documentation standards during an audit process." *Id.* at 775. The court began its analysis by noting that the utilization control provisions in 42 U.S.C. § 1396a(a)(30(A) are distinct from the rate-setting provisions, and that no court has found an enforceable right under the utilization control provisions. *Id.*

The court premised its ultimate holding – that the utilization control provision in 42 U.S.C. § 1396a(a)(30)(A) creates no rights enforceable under § 1983 – on two specific determinations. First, the court found that because utilization controls are designed to prevent waste and save money, the public treasury, not any individual, is the intended beneficiary of the statute. *Id.* at 775-76. Second, the court found that the statutory standard – "unnecessary utilization" – is so "vague and amorphous that its 'enforcement would strain judicial competence.'" *Id.* at 776 (quoting *Blessing v. Freestone*, 520 U.S. 329, 339 (1997)). On the second point the court said:

> Methods and procedures in the state plan are to be judged by whether they are 'necessary to safeguard against unnecessary utilization.' This is not a judicial standard (unlike reasonableness standards previously found to pass the non-vague test). Courts would be required to decide what regulations are necessary to do the job, either by writing the standards, clearly a legislative or administrative task, or by reviewing every proposed regulation. Federal courts are not equipped for such undertakings and separation of powers concerns are implicated also.
>
> The third [*Blessing v. Freestone*] test asks whether the statute unambiguously imposes a binding obligation on the states. In 30(a) the

> State is bound to have a plan: 'A state plan must provide such methods and procedures. . . .' But the statute itself does not provide 'notice to the States that failure to do anything other than submit a plan with the requisite features, to be approved by the Secretary, is a further condition on the receipt of funds from the Federal Government.'

Id.

(b) 42 U.S.C. § 1396d(a)(13)(Scope of Medicaid Services)

42 U.S.C. § 1396d(a) defines "medical assistance" as payment for "part or all of the cost of care and services" which are defined in §§ (a)(1)-(27). Some care and services are mandatory while others are optional; however, Medicaid can never pay for care and services other than as defined in §§ (a)(1)-(27). The statute therefore limits the scope of Medicaid state plan coverage. As such, it is directed to state Medicaid programs, not recipients. Hence, like § (a)(30)(A), § (a)(13) is an institutional policy having program-wide (aggregate) focus.

Nevertheless, the Eighth Circuit held that § (a)(13) creates rights that are privately enforceable under § 1983 because it "requires services for 'an individual,'" such that it "indicates positively both the scope of the provision and who is the intended beneficiary." App. 18. However, 20 U.S.C. § 1232g(b)(2) (FERPA), the statute at issue in *Gonzaga*, uses personal references similarly. Specifically, FERPA refers to "personally identifiable information," the "student's parents," and the "student." This Court ruled that neither these individual references nor the requirement for individual consent create any privately enforceable rights because they appear "in the context of

describing the type of 'policy or practice' that triggers a funding prohibition." *Gonzaga Univ. v. Doe*, 536 U.S. 273, 288-89 (2002).

The same can be said of § (a)(13) because the reference to "individual" appears in the context of describing the type of care that qualifies as medical assistance, that is, services that are "for the . . . restoration of an individual to the best possible functional level." "Individual" is used to define the outcomes that the service must be designed to achieve, but it says nothing about any particular intended beneficiary. The word "individual" in § (a)(13) is the linchpin of the Eighth Circuit's rationale, but it is clear that Congress used the word "individual" as a matter of form just as it used "student" or "parent" in FERPA, with no intention of creating privately enforceable rights.

Indeed, § (a)(13) contains no rights-creating language. If Congress had intended to create privately enforceable rights, it would have said something such as: "each individual Medicaid recipient is entitled to receive other diagnostic, screening, preventive, and rehabilitative services. . . ." Congress did not use such language; the section is simply an institutional policy defining and limiting the scope of Medicaid services.

(c) Provider Representation of Recipients

All three named child plaintiffs were ineligible for any CHMS care when the plaintiffs amended their complaint to challenge AFMC's medical necessity decisions. Therefore, no Medicaid eligible plaintiff had any personal stake in the medical necessity decisions being made by the board certified pediatricians engaged by AFMC. It follows that no individual plaintiff had standing to challenge those decisions. *See* U.S. CONST. art. III, § 2; *Arizonans for*

Official English v. Arizona, 520 U.S. 43, 64 (1997); *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992); *Duke Power Co. v. Carolina Envtl. Study Group, Inc.*, 438 U.S. 59, 72 (1978). The Eighth Circuit's solution was to hold that the providers represent not only themselves, but also unnamed CHMS clients who are not parties to the litigation. App. 13, 15, 19.

Assuming *arguendo* that § (a)(30)(A) or § (a)(13) create privately enforceable rights, providers do not own those rights, nor are they the recipients' attorneys. The net effect of this decision is to improperly transform the litigation into a *de facto* class action without an opportunity to contest the four class action prerequisites found in Fed. R. Civ. P. 23(a) and the considerations in Rule 23(b). Class litigation may be preferable if "adjudications with respect to individual members of the class . . . would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests." Fed. R. Civ. P. 23(b)(1)(B). As explained below, medical necessity is decided based upon the information contained in each applicant's medical record. One medical necessity decision has no effect on any other, so one decision cannot impair or impede any other applicant's ability to protect his or her interests.

Congress mandated individual adjudication of medical necessity denials, declaring that State Medicaid plans must "provide for granting an opportunity for a fair hearing before the State agency *to any individual whose claim for medical assistance* under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3) (emphasis added). Moreover, individual adjudication is required as a practical matter because pediatricians must base each CHMS medical necessity

judgment on that applicant's medical record. Consequently, there is no danger that one child's adjudication can impair the interests of another child. However, the reverse is not true. Mass adjudication and judicial interpretation of medical necessity will impose a single standard on all CHMS-eligible children, regardless of their actual medical needs.

Medical necessity adjudications are "ill-suited for class status because plaintiffs' claims hinge on whether or not the treatment for each of their individual conditions was 'medically necessary.'" (*Pecere v. Empire Blue Cross & Blue Shield,* 194 F.R.D. 66, 71 (E.D. N.Y. 2000).) Such claims "require a 'highly individualistic determination.'" *Id.* In *Selby v. Principal Mut. Life Ins. Co.,* 197 F.R.D. 48, 59 (S.D. N.Y. 2000), the defendant argued that a class should not be certified because the claim involved the denial of a medically necessary treatment. The district court agreed, relying on *Pecere.* The district court also cited to *Doe I v. Guardian Life Insurance Company of America* noting that "individual issues about each patient's treatment and policy coverage threatened to overshadow any common legal issues raised by the class members." *Selby*, 197 F.R.D. at 60 (citing *Doe I v. Guardian Life Ins. Co. of Am.*, 145 F.R.D. 466, 475-77 (N.D. Ill. 1992)).

II. THE COURT BELOW FAILED TO APPLY THE STANDARD ANNOUNCED IN *HARLOW v. FITZGERALD* AND CONFIRMED IN *MITCHELL v. FORSYTH* THAT PUBLIC OFFICIALS ARE SHIELDED FROM LIABILITY FOR DAMAGES INSOFAR AS THEIR CONDUCT DOES NOT VIOLATE CLEARLY ESTABLISHED STATUTORY OR CONSTITUTIONAL RIGHTS OF WHICH A REASONABLE PERSON WOULD HAVE KNOWN. THE COURT BELOW ALSO FAILED TO APPLY THE STANDARD ANNOUNCED IN *MONELL v. NEW YORK CITY DEPARTMENT OF SOCIAL SERVICES* THAT THERE IS NO RESPONDEAT SUPERIOR LIABILITY UNDER 42 U.S.C. § 1983.

42 U.S.C. § 1983 provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, and citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

a. Qualified Immunity

Under common law, "public officers require [immunity from § 1983 suits for damages] to shield them from undue interference with their duties and from potentially disabling threats of liability." *Harlow v. Fitzgerald*, 457 U.S. 800, 806 (1982). Accordingly, this Court has held that government officials performing discretionary functions are immune from suit and liability for civil damages under

§ 1983 "insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known." *Id.* at 818. *See also Mitchell v. Forsyth*, 472 U.S. 511, 526-28 (1985) (holding that qualified immunity is immunity from suit as well as from damages).

To overcome qualified immunity, plaintiffs must do more than show a violation of an abstract right. Plaintiffs must show that "the right the official is alleged to have violated must have been 'clearly established' in a more particularized, and hence more relevant, sense: The contours of the right must be sufficiently clear that a reasonable official would understand that what he is doing violates that right." *Anderson v. Creighton*, 483 U.S. 635, 640 (1987). This requires a two-step analysis. First, do the facts show that the official's conduct violated a statutory right? *Saucier v. Katz*, 533 U.S. 194, 201 (2001). If the answer is no, then there is no need to inquire further. *Id.* If, taking the facts in the light most favorable to the plaintiff, the official violated a statutory right, then the Court must decide whether the statutory right was clearly established. *Id.*

b. Individual Defendants' Conduct

To determine whether an official's conduct violated a statutory right it is first necessary to identify that conduct. As to Hanley's conduct the Eighth Circuit said only this: "At some point while Hanley was director, he changed the prior authorization process so that the AFMC would review not only whether the service requested was of a medically necessary type, but also inquire as to the medically necessary amount of the services." App. 6. Nothing was said about any act or omission on the part of Jeffus.

Reading the opinion in the light most favorable to the plaintiffs, Hanley was motivated to save money when he engaged AFMC to determine CHMS medical necessity,[5] and Jeffus failed to end the engagement. In other words, Hanley's offending conduct was the financially motivated establishment of QIO prior authorization as the state's "methods and procedures relating to the utilization of . . . care and services available under the plan" required by 42 U.S.C. § 1396a(a)(30)(A). Hanley undoubtedly had a legal duty to establish and maintain effective utilization controls. As a result, we turn to his choice of QIO peer review as the method of utilization control.

In addition to declaring that QIO contracts fulfill states' utilization control obligations, federal law strongly encourages states to use QIOs to make medical necessity determinations by providing financial incentives. *See* 42 U.S.C. § 1320c-7(b) (providing states 75% federal matching funds for QIO activities performed for the state) and 42 C.F.R. § 433.15(b)(6)(ii) (providing 75% federal matching funds for QIO activities rather than the 50% rate that is available under 433.15(b)(7) for utilization control performed by the state Medicaid agencies). Given that federal law explicitly authorizes and financially encourages Hanley's choice to engage AFMC, we turn to Hanley's reliance on the peer reviewers' decisions.

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[5] The Eighth Circuit gave credence to speculation that Coats was bent on eliminating CHMS. App. 10. Equal weight appears to have been given to speculation that AFMC's medical necessity determinations were designed to assure that AFMC would keep the CHMS review contract. App. 20. Obviously both suppositions cannot be true because elimination of CHMS would eliminate CHMS medical necessity reviews and AFMC's contract.

Congress mandated utilization control and established peer review to have physicians judge the necessity of health care. 42 U.S.C. § 1396a(d) provides that Hanley and Jeffus discharged their utilization control obligations by engaging a QIO to perform peer reviews. It is, therefore, apparent that Congress intended for Medicaid directors to rely upon the peer reviewers' medical judgments.

Other types of administrators also may rely on physicians' medical judgments. In deliberate indifference claims under the Eighth Amendment "the law does not clearly require an administrator with less medical training to second-guess or disregard a treating physicians' treatment decisions." *Meloy v. Bachmeier,* 302 F.3d 845, 849 (8th Cir. 2002). ERISA plan administrators may rely on the opinions of the plan's reviewing physicians. *Semien v. Life Ins. Co. of N. Am.*, 436 F.3d 805, 812 (7th Cir. 2006); *Kolosky v. UNUM Life Ins. Co. of Am.*, No. 05-1364, 2006 WL 1379633 (8th Cir. May 22, 2006). Because Hanley and Jeffus were entitled to rely on the peer reviewer's judgments, we turn to Hanley's interest in saving money.

Federal law requires effective utilization controls. Utilization controls eliminate unnecessary services, which saves money. If Medicaid directors fail to act responsibly as stewards of the public treasury and allow limited public resources to be expended for unnecessary care, Medicaid will be unable to fund all the care that is medically necessary for the truly needy. Clearly Hanley's alleged financial motivation to reserve Medicaid resources for medically necessary care was firmly grounded in federal law and his official duties, so we move on to AFMC's conduct.

c. AFMC's Conduct

The Circuit Court's qualified immunity denial focused on allegations that one of the AFMC nurse reviewers was guilty of misconduct. Specifically, the plaintiffs' allege that Nurse Coats issued several CHMS prior authorizations that did not list all the care the reviewing pediatrician determined to be medically necessary, and that the nurse reviewer's supervisors at AFMC failed to correct – and thus were complicit in – her misconduct.[6] *See* App. 7-10, 19. No other AFMC nurse reviewer is accused of similar conduct, which begs the question, why did one nurse reviewer stray from required practice? In her deposition Nurse Coats' accuser, Brenda Gassaway (who was once another CHMS nurse reviewer), testified about Nurse Coats' motivation for the alleged misconduct, saying that Nurse Coats "is crazy." Later nurse Gassaway speculated that Nurse Coats denied necessary care to enhance AFMC's status as an effective reviewer of CHMS care.[7] *See* App. 10.

d. No Respondeat Superior or Vicarious Liability

AFMC is independent of the Arkansas Medicaid program. App. 5. Though AFMC employs Nurse Coats, the peer reviewers engaged by AFMC are practicing physicians, not AFMC employees.

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[6] Of all the CHMS nurse reviewers, only Nurse Coats stands accused of altering physician determinations.

[7] There is no allegation that the CHMS review contract includes any performance standard related to the amount of care approved or disapproved. In fact, the contract says only that AFMC shall determine medical necessity.

Public officials are not liable under § 1983 unless *their conduct* violates clearly established federal rights of which a reasonable person would have known. There is no *respondeat superior* or vicarious liability. *Monell v. Dep't of Social Servs. of the City of New York*, 436 U.S. 658, 691 (1978).

Assuming that Nurse Coats was guilty of wrongdoing, AFMC cannot be held liable simply because it negligently employed or supervised a tortfeasor. *Bd. of County Comm'rs of Bryan County, Okla. v. Brown,* 520 U.S. 397, 407 (1997) ("A showing of simple or even heightened negligence will not suffice."); *Monell*, 436 U.S. at 692. Given that liability for Nurse Coats' prohibited conduct cannot extend to AFMC's chief executive officer, it should be readily apparent that liability cannot extend past her employer to Hanley or Jeffus.

The plaintiffs concede that QIO prior authorization is facially lawful, and there is no dispute that AFMC's policies are designed to produce medical necessity determinations in accordance with federal law and generally accepted medical standards prevailing in the area. In *Board of County Commissioners*, this Court held that "a plaintiff seeking to establish municipal liability on the theory that a facially lawful municipal action . . . has led an employee to violate a plaintiff's rights must demonstrate that the municipal action was not simply negligent, but was taken with 'deliberate indifference' as to its known or obvious consequences." 520 U.S. at 407 (quoting *Canton v. Harris*, 489 U.S. 378, 388-89 n.8 (1989)). Suspicion or constructive knowledge that a federal rights deprivation may occur is not enough. There must be "a finding that *this* officer was highly likely to inflict the *particular* injury suffered by the plaintiff." *Id.* at 412 (emphasis in original).

However, in this case there is no allegation or finding that it was known or obvious to Hanley and Jeffus that Nurse Coats would eliminate the specific units of care that a physician had approved for particular affected applicants.

Congress mandated the Secretary to contract with QIOs and authorized and encouraged the states to do likewise. Such contracts are prevalent nationwide, with no known reports of misconduct comparable to Nurse Coats'. Therefore Nurse Coats' misconduct was not a "known or obvious" consequence of contracting with AFMC. Furthermore, it is not enough for the consequence to be known or obvious to the official; the plaintiff must also demonstrate that Hanley and Jeffus engaged in culpable and deliberate conduct that was the moving force behind Nurse Coats' activities. *See id.* at 404.

Personal liability for Hanley and Jeffus must therefore be predicated on a showing that their deliberate and culpable action was the moving force behind Nurse Coats' activities. However, the only deliberate action that Hanley took was contracting with AFMC. That was not a culpable act because the contract conforms to federal utilization control laws. No one has identified any deliberate action that Jeffus took.

Rather than identify any culpable deliberate act on the part of Hanley or Jeffus, the Eighth Circuit credited Nurse Gassaway's speculations that Nurse Coats is "crazy" or that she sought to improve AFMC's prospects to retain its CHMS utilization contract as probable motives for her activities. Neither motive has any connection to Hanley or Jeffus, nor is it rational to conclude that their conduct was the moving force behind Nurse Coats' mental status or her speculation that by denying care she would make AFMC look better.

The Eighth Circuit properly stopped short of holding that Hanley or Jeffus should be liable because they forced a custom or usage under which AFMC denies medically necessary care. A custom or usage is a practice that is both permanent and well settled. *Monell*, 436 U.S. at 691. Nurse Coats' unilateral and unauthorized acts clearly do not fit that definition, and there is nothing in the record to suggest that Hanley, Jeffus, or AFMC had, or attempted to have, any influence over the medical necessity judgments made by independent practicing physicians.

In short, the problem was not Hanley's policies, not Jeffus' policies, and not even AFMC's policies. Rather, the problem was Nurse Coats' *failure to follow* AFMC's facially lawful policies. Failure to follow policies cannot logically subject the policy makers to liability. *Elder-Keep v. Aksamit*, No. 05-3991, 2006 WL 2389430, at *6 (8th Cir. Aug. 21, 2006). It necessarily follows that a failure to follow an independent contractor's policy cannot subject a state agency director to individual monetary liability. *City of St. Louis v. Praprotnik*, 485 U.S. 112, 128 (1988).

The last issue to consider is whether the peer reviewer's medical necessity judgments violated any clearly established rights. The question is not whether the right exists in an abstract sense, but whether in a "more particularized" way, the contours of the right were, at the time of the alleged violation, "sufficiently clear that a reasonable official would understand that what he is doing violates that right." *Anderson v. Creighton,* 483 U.S. 635, 640 (1987). Or, as *Saucier* put it: "[t]he relevant, dispositive inquiry in determining whether a right is clearly established is whether it would be clear to a reasonable [official] that his conduct was unlawful in the situation he confronted." 533 U.S. at 202. In other words, an official is

entitled to qualified immunity even if he wrongly, but reasonably, believed his actions were lawful. *Malley v. Briggs*, 475 U.S. 335, 341 (1986).

Congress established peer review to enable physicians to "judge whether services ordered by other physicians are necessary." S. REP. 92-1230 at 256 (1972). When it created the peer review system, Congress clearly intended that Medicaid directors give effect to the peer reviewers' judgments. Hanley and Jeffus could not have suspected that by following federal peer review law they violated a clearly established federal right.

Likewise, Congress has not enacted any statute obligating Medicaid directors to ignore or overturn federally designated peer reviewers' medical judgments. Nor is there a clearly established federal right to compel any peer review decision other than a decision approving such care as is medically necessary in the reviewer's professional judgment. Certainly there is no privately enforceable federal right to any particular amount of CHMS day care in all cases, particularly when a peer reviewer opines that no medical need exists for that much treatment.

Laid bare, the Eighth Circuit decision boils down to this: Medicaid directors can be forced to defend against personal monetary damage suits for the cost of the disputed medical care when federally certified peer reviewers decide care is medically unnecessary, or a QIO employee abuses his or her authority. The Eighth Circuit's implicit findings – that the intent to conserve Medicaid resources somehow creates an inference of wrongdoing, and that peer review contracts somehow impel wrongdoing – flatly contradict the program integrity measures enacted by Congress.

The Eighth Circuit's decision forcing Hanley and Jeffus to stand trial can only impede states' efforts to employ and retain qualified Medicaid directors. Health care administrators will reasonably fear that contracting for peer review or establishing meaningful utilization programs will expose them to staggering personal monetary liability.

Congress, however, provided that utilization controls must be effective. 42 U.S.C. § 1396a(a)(30)(A). That cannot happen if utilization controllers live in fear that medical necessity decisions may subject them to suit and leave them penniless. Understanding this, Congress enacted QIO immunity in 42 U.S.C. § 1320c-6(b). Given that QIOs, their employees, and independent physician reviewers are immune from liability for medical necessity decisions, it cannot logically follow that an official who authorized the QIO contract can personally be liable for money damages for those very decisions. By holding that Medicaid directors who contract with QIOs in accordance with federal law may be liable for QIO medical necessity decisions, the Eighth Circuit did precisely what Congress plainly prohibited in § 1320c-6(b): it paved the way for Medicaid providers and recipients to harass and intimidate public officials in retaliation for them carrying out program integrity functions mandated by federal law.

Physician peer review is the cornerstone of federally funded healthcare utilization oversight. History shows that public health care costs rapidly spiral out of control without effective utilization oversight. It is not an exaggeration to say that Medicare and Medicaid cannot remain viable without peer review and other program integrity measures.

Congress intended for physicians to make medical necessity decisions subject to review under each state's administrative procedure act. Congress did not intend federal district courts to confer upon themselves jurisdiction to assert control over physician peer reviewers' medical necessity judgments. The Eighth Circuit's decision holds that Medicaid administrators may be personally liable for peer review decisions. Implicit in that decision is a new rule of law allowing federal courts to supplant peer review in a way that Congress clearly did not foresee or intend.

Undoubtedly the decision to contract with AFMC was a discretionary act that was explicitly permitted and encouraged by federal law. Qualified immunity is designed to enable public officials to make such discretionary decisions independently and without fear of consequences. *Mitchell v. Forsyth*, 472 U.S. 511, 526-27 (1985). The result reached by the Eighth Circuit stands this concept on its head, is contrary to the law in all other circuits, applies the wrong legal standards, and opens a floodgate of lawsuits against public servants who administrator federally funded healthcare programs.

Respectfully submitted,

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443 F.3d 1005

United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 05-1668

Pediatric Specialty Care, Inc.; Child & Youth Pediatric Day Clinics, Inc.; Family Counseling & Diagnostic Clinic; Tomorrow's Child Learning Center, LLC; D & D Family Enterprises, Inc.; James Swindle; Stacey Swindle, as parents and next best friends of Jacob and Noah Swindle, Minors; Susann Crespino, as parent and next best friend of Michael Crespino, a minor;

Plaintiffs-Appellees,

v.

Arkansas Department Of Human Services;

Defendant-Appellant,

Kurt Knickrehm, in his individual capacity and in his official capacity as Director of the Arkansas Department of Human Services;

Defendant,

Appeal From the United States District Court for the Eastern District of Arkansas.

Ray Hanley, in his individual capacity as Director of the Division of Medical Services of The Arkansas Department of Human Services;

Defendant-Appellant,

Arkansas Foundation for Medical Care;

Defendant,

Roy Jeffus, in his official capacity as Interim Director of Arkansas Department of Human Services Division of Medical Services;

Defendant-Appellant.

Submitted: Feb. 15, 2006
Filed: April 17, 2006

Before SMITH, HEANEY, and BENTON, Circuit Judges.

HEANEY, Circuit Judge.

This case, which involves disputes about the medical services that Arkansas provides to needy children, returns to this court following two prior appeals and remands for further proceedings. In its first appeal, the Arkansas Department of Human Services (ADHS) challenged a district court injunction that forced it to keep its Child Health Management Services (CHMS) program as part of its state Medicaid plan. We held that, pursuant to the Medicaid Act, children had an enforceable right to early

and periodic screening, diagnosis, and treatment (EPSDT) services. *Pediatric Specialty Care. Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472, 478-79 (8th Cir. 2002) (hereinafter *Pediatric I*). We reversed the injunction, however, to the extent that it required ADHS to continue the CHMS program as part of its state plan. *Id.* at 480. So long as the state continued to pay for CHMS-type services when prescribed by a doctor, we reasoned, the state fulfilled its obligations under the Medicaid Act. *Id.* at 480-81. We then remanded for further proceedings.

On remand, the district court considered the plaintiffs' procedural and substantive due process claims. The district court held that ADHS violated the procedural due process rights of the plaintiffs by attempting to change the CHMS program without first conducting a study about the effect such a change would have on the efficiency, economy, quality of care, and access to care, as required by 42 U.S.C. § 1396a(a)(30)(A). It further held that ADHS had engaged in "conscience shocking" behavior by trying to reduce medical services to needy children based on political and fiscal motivations. On appeal, we affirmed the district court's ruling on the plaintiffs' procedural due process claim. *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 364 F.3d 925, 929-31 (8th Cir. 2004) (hereinafter *Pediatric II*). As to the substantive due process claim, however, we held that ADHS's attempt to move CHMS services "off-plan" for cost savings was not conscience shocking, and thus reversed the district court's contrary holding. *Id.* at 932. We again remanded for further proceedings.

On remand, the district court considered, among other things, damages claims against Kurt Knickrehm, Ray Hanley, and Roy Jeffus, all current or past high-level

supervisors of ADHS.[1] Knickrehm, Hanley, and Jeffus moved for summary judgment, asserting they were entitled to qualified immunity. ADHS contended that it was entitled to absolute immunity under the Eleventh Amendment because it was an agency of the state of Arkansas. The district court granted the motion as to Knickrehm, but denied it as to Hanley and Jeffus. Although its order expressly disposed of all of the defendants' other summary judgment claims, it was silent regarding ADHS's Eleventh Amendment argument.

On appeal, Hanley and Jeffus contend that the district court erred in denying their claim for summary judgment based on qualified immunity. ADHS argues that the district court erred in failing to grant it summary judgment based on Eleventh Amendment immunity. We find no error in the district court's conclusion that Hanley and Jeffus are not entitled to summary judgment on this basis. On ADHS's Eleventh Amendment claim, we agree that it must be dismissed from the suit as an agency of the state. Our review of the record, however, indicates that the plaintiffs have sought prospective injunctive relief from ADHS by suing its directors, and ADHS has admitted that its officials can be sued for the purpose of seeking prospective injunctions. Thus, we affirm in part, but direct the district court on remand to dismiss ADHS from the suit.

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[1] Knickrehm has been director of ADHS since January of 1999; Hanley was director of the Division of Medical Services of ADHS from 1994 through January 6, 2003; Jeffus has been director of the Division of Medical Services from January 6, 2003 to the present.

BACKGROUND

Much of the background of this dispute has been recounted in our prior opinions of *Pediatric I* and *Pediatric II*, and will not be fully restated here. The plaintiffs include medical clinics that provide EPSDT services to special needs children in Arkansas and recipients of those services. The services are provided for the purpose of increasing the functional levels of developmentally impaired children. These services have been offered in Arkansas through the CHMS model, which "extends diagnostic and evaluative services, pediatric day treatment, and various therapies to children from six months to six years of age." *Pediatric II*, 364 F.3d at 928.

Over the past several years, ADHS has tried to curtail its payments for CHMS services. In November of 2001, ADHS issued a press release stating that it would restructure the CHMS program, terminating day treatment and therapeutic programs, resulting in a savings of several million dollars. As relevant to this appeal, the plaintiffs have alleged[2] that Hanley, Jeffus, and the ADHS employed a system requiring prior authorization for CHMS services solely for budget-related reasons without consideration of the medical necessity of the services.

The prior authorization regime was operated by Arkansas Foundation for Medical Care (AFMC), an independent organization that contracted to provide this service to ADHS. Beginning in July of 2001,[3] AFMC was

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[2] These allegations were made through an amended complaint that was filed after the appeal in *Pediatrics II* was already pending.

[3] ADHS entered into two contracts with AFMC, one extending from July 1, 2001 through June 30, 2003, and another from July 1, 2003 through June 30, 2005.

presented with applications for CHMS services, and was tasked with determining whether the requested services were medically necessary based on a review of the child's medical records. First, a nurse reviewer received a CHMS provider's request for prior authorization. If the nurse reviewer did not approve the plan, it was sent to a physician reviewer. If the physician reviewer denied the services, the provider could ask for reconsideration, and the plan would be reviewed by a second physician. Nurse reviewers may not override a doctor's decision to recommend services.

At some point while Hanley was director, he changed the prior authorization process so that the AFMC would review not only whether the service requested was of a medically necessary type, but also inquire as to the medically necessary amount of the service. This essentially led to a wholesale reduction in CHMS services from six hours per day, per child to no more than three and one-half to four hours per day, per child.

The plaintiffs presented evidence from their expert, Dr. Sharon Ramey. Dr. Ramey testified that six hours per day of services is most effective for needy children. The district court believed that Dr. Ramey's testimony, taken in the light most favorable to the plaintiffs, raised an inference that the prior authorization procedure's reduction in CHMS services was based on considerations other than the medical necessity of the children.

Dr. John Whitaker was a doctor reviewer who worked for AFMC. He testified that AFMC used guidelines that only permitted nurses to approve up to three and one-half hours of CHMS services for children. He stated that he would not generally approve six hours of CHMS services

for a child because, in his view, a child could not be expected to get beneficial results for more than four hours per day of a CHMS program. He further testified that, at the request of nurse supervisor Amy Carson, he had developed what he termed "rote denials" or "canned denials," which were pre-scripted denial letters[4] that nurses were supposed to use for certain types of claims that were easily disposed of.

According to Dr. Whitaker, it came to his attention in December of 2003 that one of AFMC's nurse reviewers, Tilerra Coats, was reducing CHMS services far greater than she should have been, and misusing his denial codes. Whitaker began to institute quality control on Coats's work, randomly checking the entire file in which she would recommend reduced services. On each occasion, Dr. Whitaker subsequently approved the child for more care than Coats had. In some instances, despite Dr. Whitaker's direction, the ultimate decision was not changed, and the child would receive less care than Dr. Whitaker had authorized. Dr. Whitaker also discovered that Coats was often altering his approvals to provide less service to the children. Dr. Whitaker brought this problem to the attention of Carson, Coats's supervisor, but nothing was done to correct matters. In fact, when Dr. Whitaker audited some of his past charts, he noticed that Carson had actually signed off on charts that Coats had altered. On further inquiry, Carson had written on a number of these files what she believed was the rationale for the files not accurately reflecting the services approved by Dr.

[4] Dr. Whitaker clarified in his deposition that although they termed these denial letters, they were actually partial approvals of services, but in an amount or to a degree less than requested.

Whitaker. Most often her explanation was merely her own opinion stating that she did not believe the services were necessary, or supporting Coats's opinion to that effect. Neither Coats, Carson, nor any other nurse, however, is permitted to change a physician's recommendations for CHMS services. Dr. Whitaker also discovered that some of his charts had been altered in a manner that made the children under review appear not to qualify for either the extent or degree of services he approved. When Dr. Whitaker sought an explanation for this, written notes on at least one of his charts indicated that his authorized service was not given because "the directive I[5] received from [ADHS] was to only approve 1 unit of 99211[6] per day." (Whitaker Dep. at 77.)

Dr. Whitaker was also informed that Coats was re-reviewing other nurses' work, and would often change the recommendations to approve fewer services for the children. In these instances, Coats would typically erase the prior nurse's review so that it looked like hers was the only review. Dr. Whitaker was not aware of any instance in which a nurse reviewer, either intentionally or mistakenly, increased the amount of services approved over what a physician had recommended. Dr. Whitaker eventually reported this wrongdoing to Dr. Susan Keathley, who brought it to the attention of Dr. Moody, the medical director for AFMC.

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[5] It is unclear from the deposition if the "I" in this sentence is Coats or Carson.

[6] 99211 is a procedure code used for CHMS services. It refers to an office visit of an established patient for some reason. One unit is five minutes. In this instance, Dr. Whitaker had approved 40 units per month for a child's catheterization needs, but that had been reduced by a nurse to 20 units per month.

Brenda Gassaway is a registered nurse who was formerly employed as a nurse reviewer by AFMC. She began working for AFMC on April 10, 2000, and was fired on July 19, 2004. Gassaway stated that she knew about the problem of Coats changing doctors' files as early as January of 2002. Gassaway had been passing on this information to her supervisor, Carson, for a year and a half. Carson told Gassaway that they would have to handle matters carefully because Coats and Kenya Harbin, director of the review department, were close friends.

In early July of 2004, Gassaway was called into a meeting with Harbin and Susie Moore, the director of human resources. The meeting concerned Dr. Whitaker's claims of nurse wrongdoing. According to Gassaway, Dr. Moody sent the matter back to Harbin for investigation, and she then interviewed each of the nurse reviewers to determine who had helped Whitaker discover the altered files. Gassaway denied involvement, but told Harbin that she knew Coats was altering doctors' decisions. Harbin responded that they had reviewed the matter and found those allegations unsubstantiated. At that point, Gassaway concluded that the sole purpose of the meeting was to determine if Dr. Whitaker had acted inappropriately in auditing Coats's work and if anyone had helped him. Eventually, Harbin accused Gassaway of copying charts for Dr. Whitaker, which Gassaway continued to deny. As the meeting concluded, Gassaway again told Harbin to correct AFMC's wrongdoings. Harbin's response was to tell Gassaway not to discuss the meeting with anyone else.[7]

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[7] Similarly, Brenda Gassaway testified in her deposition that she told Michael Rainwater, attorney for AFMC, about AFMC's canned-denial

(Continued on following page)

Gassaway was fired a week later for insubordination and failure to follow the chain of command.

When asked at his deposition about how AFMC interacts with CHMS providers, Dr. Moody stated that AFMC regularly puts out memos to assist CHMS providers in knowing what kind of documentation is required. Gassaway disagreed:

> No, that was not the truth. The truth is no matter what [CHMS providers] ask for you don't give it to them ever until they beg for it, and then you show up with someone who doesn't know so that you can say, "The person you need is not here." That's the truth.

(Gassaway Dep. at 22.)

Gassaway believed that Coats was not only changing doctors' charts, but also altering other nurses' work to reduce approved services. When asked what might motivate Coats to alter doctors' and nurses' files, Gassaway stated, "[b]ecause she's crazy." (*Id.* at 27.) She elaborated that Coats had stated that she did not think that any child deserved any services whatsoever, and that the CHMS program was just expensive daycare. When asked again what incentive Coats had to illegally reduce the services, Gassaway speculated that it was because of the cost savings attributable to AFMC's reviews. Gassaway stated that both Carson (her direct supervisor) and Harbin (an AFMC vice president) had stated that AFMC's cost-savings reports, which were reports generated and

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procedure, and he instructed her "don't bring it up" at her deposition. (Gassaway Dep. at 18.) Breck Hopkins, attorney for ADHS, was also present.

published to ADHS about the amount of money AFMC had saved ADHS through the review process, justified ADHS renewing AFMC's contract. Gassaway termed this as the general sentiment at AFMC, which every employee is aware of. As she stated, "I worked there for four years and I saw the patterns of how the programs are worked and it just seems that the goal is always to cut services and to make [CHMS] centers jump through hoops to get the kids approved so that they'll just quit." (*Id.* at 36.) She also testified that she received written and oral directives from Carson, which Carson had in turn received from Shirley Wilson, a former director of ADHS, that they should generally deny certain requests for services, such as those requested for children with only a single disability.

Based in large part upon the deposition testimony of Gassaway and Dr. Whitaker, the district court determined that individual defendants Hanley and Jeffus were not entitled to qualified immunity. The court noted that the plaintiffs sought damages for the violation of clearly established rights to Medicaid services. As to whether the evidence supported the inference that such a violation occurred, the court stated

> Plaintiffs alleged and have offered sufficient evidence that a second layer of the prior authorization process was implemented by the individual capacity defendants resulting in an across-the-board reduction in the scope and duration of day treatment recommended by the CHMS providers. Consequently, all medicaid eligible children were allegedly denied their full array of recommended treatment. Plaintiffs contend that this reduction has violated the equal access provision of the Medicaid Act as well as entitlement to day treatment in accordance with [42 U.S.C.]

> § 1396d(a)(13). There is sufficient evidence in the record [to] raise a reasonable inference that the conduct of Defendants reduced the quality of care available to low income children as compared to other children in the general population. Moreover, there is sufficient evidence that costs for the additional hours of care may be borne by the CHMS providers to such an extent that it jeopardizes the future availability of their services. Finally, according to Ms. Gassaway, elimination of such services is the goal of the prior authorization practices engaged in by AFMC with the encouragement and tacit approval of Defendants.

(Dist. Ct. Order of Feb. 7, 2005 at 34-35.)

The court did not specifically rule on the issue of whether ADHS, as an agency of the state, was entitled to summary judgment on the basis of Eleventh Amendment immunity. This interlocutory appeal by Hanley, Jeffus, and ADHS followed.

ANALYSIS

I. QUALIFIED IMMUNITY OF HANLEY AND JEFFUS.

"Ordinarily, a party cannot appeal from a denial of summary judgment." *Pool v. Sebastian County, Arkansas*, 418 F.3d 934, 937 (8th Cir. 2005). There is an exception to this rule for government officials whose motion for summary judgment based on qualified immunity is denied. *Id.* Under this exception, we may immediately review the issue of whether the defendants engaged in conduct that violated the plaintiffs' clearly established rights. *Id.; see also Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982) (holding that "government officials performing discretionary

functions generally are shielded from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known").

We must first consider whether the Medicaid Act confers any federally enforceable rights upon the plaintiffs. This question has been largely answered by our prior opinions in this case. The claims for damages made by the plaintiffs here relate only to two subsections of the Medicaid Act: 42 U.S.C. § 1396d(a)(13) (Count Four of the Complaint), and 42 U.S.C. § 1396a(a)(30)(A) (Count Three of the Complaint). In *Pediatrics I* and *Pediatrics II*, respectively, we specifically held that each of these subsections created enforceable federal rights. *Pediatrics I*, 293 F.3d at 480-81 (holding that § 1396d(a)(13) created enforceable rights for recipient beneficiaries, which CHMS providers could assert on behalf of the beneficiaries); *Pediatrics II*, 364 F.3d at 930 ("Over ten years ago, our court held that § 1396a(a)(30)(A) created enforceable rights for Medicaid recipients and providers. We find it entirely appropriate for the Plaintiffs to base their procedural due process claim on their clearly established rights to have equal access to quality medical care as defined by § 1396a(a)(30)(A)." (Citation omitted)). Thus, the argument that there is no federally enforceable rights here is at odds with both the law of the case doctrine and the principle of stare decisis.[8]

[8] Under the doctrine of stare decisis, one panel may not overrule an earlier decision of the court. *United States v. Mosby*, 101 F.3d 1278, 1279 n. 3 (8th Cir. 1996). Because the analysis of the stare decisis issue on this matter is rendered unnecessary by operation of the law of the case doctrine, we have not separately addressed it. *See id.*

"The law of the case doctrine prevents the relitigation of a settled issue in a case and requires courts to adhere to decisions made in earlier proceedings," except where the result would be manifestly unjust. *Kan. Pub. Employees Ret. Sys. v. Blackwell, Sanders, Matheny, Weary & Lombardi, L.C.*, 114 F.3d 679, 687 (8th Cir. 1997). Stated another way, when our court considers a case on appeal, every issue disposed of on appeal has thus been finally decided. *Klein v. Arkoma Prod. Co.*, 73 F.3d 779, 784 (8th Cir. 1996). The doctrine is intended to "'insure uniformity of decisions, protect the expectations of the parties and promote judicial economy.'" *In re Just Brakes Corp. Sys., Inc.*, 293 F.3d 1069, 1072 (8th Cir. 2002) (quoting *Klein*, 73 F.3d at 784). The doctrine does not apply, however, where an intervening decision of a higher tribunal clearly demonstrates that the prior decision is wrong. *Madison v. IBP, Inc.*, 330 F.3d 1051, 1059 (8th Cir. 2003).

42 U.S.C. § 1396d(a)(13) entitles Medicaid eligible children to

> diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

In *Pediatrics I*, we affirmed the district court's holding that this subsection of the Medicaid Act created an enforceable federal right to early intervention day treatment when recommended by a physician. *Pediatrics I*, 293 F.3d at 477-78. No petition for rehearing was filed by the

ADHS. *Cf. Klein*, 73 F.3d at 784 n. 7 ("Generally, parties must bring any perceived errors in a panel opinion to the court's attention through a petition for rehearing.")

Similarly, 42 U.S.C. § 1396a(a)(30)(A), commonly referred to as the "equal access provision" of the Medicaid Act, requires state Medicaid plans to employ methods and procedures related to use and payment of care and services as necessary to ensure that the state's payments are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Relying in part on our earlier opinion in *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993), we held that this part of the Medicaid Act created a clearly established federal right to equal access to quality medical care. *Pediatrics II*, 364 F.3d at 930. ADHS petitioned for rehearing en banc from this decision, but nowhere in the petition did ADHS suggest that it was error to find that the equal access provision created an enforceable federal right.

Given our clear prior panel holdings, the question of whether §§ 1396d(a)(13) and 1396a(a)(30)(a) confer enforceable federal rights upon the plaintiffs appears settled in the affirmative. Although ADHS suggests that *Pediatrics I* did not finally answer whether CHMS providers had an enforceable right under § 1396d(a)(13), we explicitly stated that the providers have "standing to assert the rights of their CHMS patients." 293 F.3d at 478. Thus, there is little merit to that argument.

ADHS invites us to overturn our prior decisions based on the view that they are inconsistent with the Supreme

Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002). According to ADHS, *Gonzaga* clarified that an enforceable right is only created where the statute explicitly states as much, and is only enforceable by the person or entity that the statute states is the beneficiary.

At the outset, we note that *Gonzaga* was issued on June 20, 2002. Our decision in *Pediatrics I* was filed ten days earlier, but the mandate did not issue until July 1, 2002, with no petition for rehearing before that time. *See* Fed. R. App. P. 40(a) (granting a party fourteen days from the entry of judgment to file a petition for rehearing). Likewise, our decision in *Pediatrics II* was not issued until April 16, 2004. Thus, *Gonzaga* is not an intervening decision of a superior tribunal, as is required before we may overturn matters previously settled as the law of the case. *Madison*, 330 F.3d at 1059.

Perhaps more importantly, we do not read *Gonzaga* to require a different result than we reached in our earlier decisions. In *Gonzaga*, the question presented was whether a student could bring a damages claim pursuant to 42 U.S.C. § 1983 for a University's violation of the Family Educational Rights and Privacy Act of 1974 (FERPA). 536 U.S. at 276. FERPA was enacted pursuant to Congress's spending power, and directed the Secretary of Education to withhold funds from institutions that released students' private information without their consent. *Id.* at 278. A student at Gonzaga's school of education sued the school under FERPA when he found out that the school's teacher certification specialist disclosed allegations of sexual misconduct to Washington's teacher certification agency without his permission. *Id.* at 277.

Writing for the majority, Chief Justice Rehnquist first recognized that there was some circuit and district court discord and confusion about what type of statutory rights were enforceable by a § 1983 damages action. *Id.* at 278. The Court noted that the starting point must be an inquiry into whether Congress intended to create a federal right. *Id.* To determine this, one must consider the benefit conferred by the statute, the intended beneficiary, and whether the statute provides for some type of enforcement action short of a private cause of action. *Id.* at 285-90. The Court stated that the creation of such rights must be done "in clear and unambiguous terms." *Id.* at 290. The Court ultimately held that FERPA provisions failed to create privately enforceable rights, since it had no explicit "rights-creating language," spoke in terms of aggregate as opposed to individual privacy protections, and directed the Secretary of Education to enforce it. *Id.*

ADHS would have us read *Gonzaga* in a manner that forecloses private causes of action based on the Medicaid Act. However, an earlier case, *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), has already considered whether (now-repealed) provisions of the Medicaid Act, which required the state to reimburse hospitals for costs of certain services, conferred a § 1983 right of action on behalf of health care providers. The Court first held that "[t]here can be little doubt that health care providers are the intended beneficiaries" of the provision, since it was about payment of services provided by them. *Id.* at 510. The Court then concluded that the mandatory language of the provision – requiring some level of payment for the health care providers' services even though the ultimate amount was left mostly to the state's discretion – created an enforceable right to payment under § 1983. *Id.* at

512-13. Although *Gonzaga* takes a more restrictive view of rights-creating statutes, it did not overrule *Wilder*. Thus, the proposition that the Medicaid Act may create enforceable rights, even for health care providers, is far from novel.

Secondly, the plaintiffs still prevail within the terms of the *Gonzaga* analytical framework. As to § 1396d(a)(13), the statute calls for state payment of part or all of the costs of diagnostic, screening, preventive, and rehabilitative services when recommended by a doctor "for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." The intended beneficiaries of this subsection are, obviously, the needy child, and by corollary, those who incur costs in providing those services. Moreover, this portion of the statute does not speak in terms of amorphous concepts; it requires therapeutic services for "an individual." *Id.* We acknowledge that the federal government is charged with responsibility for supervising a state's participation in the Medicaid program, a factor that *Gonzaga* holds indicative of no private right being created. This, however, cannot overcome the fact that the statute itself indicates positively both the scope of the provision and who is the intended beneficiary. Thus, a private cause of action lies for enforcement of § 1396d(a)(13).

Similarly, 42 U.S.C. § 1396a(a)(30)(A), is intended to benefit both CHMS recipients and providers, and creates enforceable rights for both groups. That subsection requires states to provide methods and procedures for payment of care and services in a manner that ensures equal access to quality care for needy children. *Id.* The beneficiaries are both the recipients of the services and the recipients of the state's payment, who are the CHMS

providers. The statute is clear on its scope: to ensure payments are not too high, but yet high enough to secure the participation of enough clinics so that needy children receive equal access to quality health care.

In sum, as our prior cases have held, the rights conferred by §§ 1396d(a)(13) and 1396a(a)(30)(A) are clearly established federal rights. Moreover, even accepting ADHS's invitation to reconsider prior established precedent, we find no error in the district court's holding that these provisions of the Medicaid Act are enforceable by both CHMS recipients and providers through a § 1983 private cause of action.

We must now consider whether the evidence, viewed in the light most favorable to the plaintiffs, *Plemmons v. Roberts*, 439 F.3d 818, 822 (8th Cir. 2006), supports the view that Hanley and Jeffus violated the plaintiffs' Medicaid Act rights. The district court found that, taking all evidence and inferences in the plaintiffs' favor, they could show that Jeffus and Hanley manipulated the prior authorization system in a way that denied children essential medical services solely because they wanted to cut costs. After carefully reviewing the record, we agree with the district court.

The evidence presented to the district court is recounted fully above, and will be merely summarized here. There is certainly evidence that documented AFMC's wrongdoing: Dr. Whitaker testified about how his approvals had been altered by a nurse, and Brenda Gassaway, a nurse, testified consistently with that. When brought to the attention of supervisors, nothing was done to correct this misconduct. To the contrary, Gassaway herself was fired.

The more difficult question is whether ADHS's directors can be tied to this wrongdoing. Although disputed and certainly not proven, the inference of wrongdoing is supported by the plaintiffs' evidence. Deposition testimony indicated that AFMC's primary concern was to save ADHS money, and Gassaway stated that her superiors told her that this was the reason they were able to maintain the contract with ADHS. In other words, AFMC won and kept the contract as ADHS's prior authorization agent because it would deny or reduce a significant number of claims when compared to the services paid prior to AFMC's arrival. There was also testimony that ADHS worked overtly to ensure that claims were denied by sending directives to AFMC about the extent of services that AFMC could approve. As recognized by the district court, Hanley and Jeffus "implemented a policy [of prior authorization] that reduced the scope and duration of day treatment for beneficiaries of the Medicaid Act." (Dist. Ct. Order of Feb. 7, 2005 at 38.) Taking the evidence in the plaintiffs' favor, one could infer that their primary motivation was to save money, although the statutes require them to act in the best interest of the needy children. That is a violation of the rights clearly established under the §§ 1396d(a)(13) and 396a(a)(30)(A) and our prior caselaw, and thus neither defendant is entitled to summary judgment on the issue of qualified immunity. The district court properly so held.

II. STATE IMMUNITY FROM SUIT

ADHS argues that it must be dismissed from this suit because it is an agency of the state, and thus enjoys

Eleventh Amendment immunity from suits by private individuals.[9] The Eleventh Amendment protects states and state agencies from suit by private citizens. *Doe v. Nebraska*, 345 F.3d 593, 597 (8th Cir. 2003). According to the doctrine of *Ex Parte Young*, 209 U.S. 123 (1908), however, state officials may still be sued for prospective injunctive relief without violating the Eleventh Amendment. *Heartland Acad. Cmty. Church v. Waddle*, 427 F.3d 525, 530 (8th Cir. 2005).

In this case, ADHS has asserted Eleventh Amendment immunity as a branch of the state. ADHS therefore claims that the district court erred in allowing damages claims to go forward against it. The plaintiffs responded by stating that they were not suing ADHS for damages, only for prospective injunctive relief. ADHS argues that it is nonetheless entitled to immunity because only state officials, as opposed to state agencies, can be sued for prospective injunctive relief. While that is true, *Allen*, 5 F.3d at 1153 (affirming dismissal of a state agency on Eleventh Amendment grounds), the plaintiffs sued not only ADHS, but also Knickrehm and Jeffus in their official capacities as director of ADHS and director of the Division of Medical Services for ADHS, respectively. To the extent the plaintiffs' claims are against ADHS, they must be

[9] The district court's order contains no ruling on this issue, raising a question of whether it is properly presented to us. That said, we review Eleventh Amendment issues de novo, *Allen v. Purkett*, 5 F.3d 1151, 1153 (8th Cir. 1993) (per curiam), and neither party has raised a factual dispute related to this issue. Particularly given the lengthy history of this case, which has yet to be tried on its merits, we see no use in returning this matter to the district court for a decision that we would again review with no deference.

dismissed, but claims against the directors in their official capacity are not barred by the Eleventh Amendment.

CONCLUSION

The current and former directors of the Arkansas Department of Human Services appeal the denial of qualified immunity on the plaintiffs' claims relating to their clearly established rights under the Medicaid Act. Because the evidence supports an inference that they violated the plaintiffs' clearly established rights to provide and receive medically necessary health care, we affirm the denial of summary judgment on that basis.

We agree that claims against ADHS, as an agency, must be dismissed on Eleventh Amendment grounds. Because the plaintiffs have also asserted claims seeking prospective injunctive relief against state officials, such claims are not barred by the Eleventh Amendment. Accordingly, we affirm in part, and remand with directions to dismiss ADHS from the suit.

United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 05-1668

Pediatric Specialty Care, Inc.; Child & Youth Pediatric Day Clinics, Inc.; Family Counseling & Diagnostic Clinic; Tomorrow's Child Learning Center, LLC; D&D Family Enterprises, Inc.; James Swindle; Stacey Swindle, as parents and next best friends of Jacob and Noah Swindle, Minors; Susann Crespino, as parent and next best friend of Michael Crespino, a minor;	*	4:01CV00830
Plaintiffs-Appellees,	*	
v.	*	Appeal From the
Arkansas Department of Human Services;	*	United States District Court for the Eastern
Defendant-Appellant,	*	District of Arkansas.
Kurt Knickrehm, in his individual capacity and in his official capacity as Director of the Arkansas Department of Human Services;	*	
Defendant,	*	
Ray Hanley, in his individual capacity as Director of the Division of Medical Services of The Arkansas Department of Human Services;	*	
Defendant-Appellant,	*	

Arkansas Foundation for Medical Care;	*
	*
Defendant,	*
	*
Roy Jeffus, in his official capacity as Interim Director of Arkansas Department of Human Services Division of Medical Services;	*
	*
	*
	*
	*
	*
Defendant-Appellant.	*

JUDGMENT

This appeal from the United States District Court was submitted on the record of the district court, briefs of the patties and was argued by counsel.

After consideration, it is hereby ordered and adjudged that the judgment of the district court in this cause is affirmed in part and remanded in accordance with the opinion of this Court.

(5172-010199)

April 17, 2006

Order Entered in Accordance with Opinion:

/s/ Michael E. Gans

Clerk, U.S. Court of Appeals, Eighth Circuit.

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

PEDIATRIC SPECIALTY CARE, INC.; CHILD & YOUTH PEDIATRIC DAY CLINICS, INC.; TOMORROW'S CHILD LEARNING CENTER, LLC; JAMES and STACEY SWINDLE, as parents and next friends of JACOB and NOAH SWINDLE, minors; and SUSANN CRESPINO, as parent and next friend of MICHAEL CRESPINO, a minor — PLAINTIFFS

VS. Case No. 4:01CV00830 WRW

ARKANSAS DEPARTMENT OF HUMAN SERVICES; KURT KNICKREHM, in his individual and official capacity as DIRECTOR OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES; RAY HANLEY, in his individual capacity as Director of the Arkansas Department of Human Services Division of Medical Services; ARKANSAS FOUNDATION FOR MEDICAL CARE, INC.; and ROY JEFFUS, in his official capacity as Interim Director of Arkansas Department of Human Services Division of Medical Services — DEFENDANTS/THIRD-PARTY PLAINTIFFS

VS.

THE UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES; TOMMY THOMPSON,

Secretary of the United States Department of Health & Human Services, in his official capacity; and MARK MCCLELLAN, Administrator, United States Department of Health & Human Services Center for Medicare & Medicaid Services, in his Official Capacity — THIRD-PARTY DEFENDANTS

ORDER

(Filed Feb. 7, 2005)

Pending are Defendants Arkansas Department of Human Services (ADHS), Kurt Knickrehm, Roy Jeffus and Ray Hanley's Motion for Summary Judgment (Doc. No. 162), Supplemental Motion for Summary Judgment (Doc. No. 253), and Motion for Ruling on Qualified Immunity Issue (Doc. No. 221). For the reasons stated below, Defendants' Motion for Summary Judgment and Supplemental Motion are DENIED except with respect to the individual liability of separate Defendant Kirk Knickrehm for civil damages. Defendants' Motion for Ruling on Qualified Immunity is DENIED as MOOT.

I. BACKGROUND

Plaintiffs are composed of medical providers for, and medicaid recipients of special benefits mandated by the Social Security Act ("SSA"). These benefits are identified as Early Periodic Screening Diagnostic and Treatment Services ("EPSDT"). The services are designed to restore developmentally impaired children to their best possible functional level. Arkansas uses a health care model program to effectuate EPSDT benefits: the Child Health Management Services program ("CHMS"). Clinics licensed

under the CHMS program provide diagnostic screening and treatment to children to help reduce physical and mental impairments and to ready them for school. Included in the program are day treatment clinics that provide daily monitoring, care, and therapy for eligible children.

Plaintiffs are CHMS providers and recipients. Plaintiffs filed a complaint and five subsequent amended complaints[1] alleging that Defendants, Arkansas Department of Human Services ("ADHS"),Kurt Knickrehm, Ray Hanley, and Roy Jeffus intentionally violated §§ 1396 (a)(30)(A), 1396a(a)(8), 1396a(a)(3), and 1396d(a)(13) of the SSA by implementing and manipulating a prior authorization process for the sole purpose of meeting general budget concerns; without considering economy, efficiency, quality of care, and equal access. In addition, Plaintiffs contend that budget concerns overshadowed the real purpose of the entitlement program – maximum reduction of disability. Plaintiffs also allege that Defendants violated their procedural and substantive due process rights. Plaintiffs' Fifth Amended Complaint adds allegations of misrepresentation and fraud in the peer review process – a process utilized by Defendants to review and authorize eligibility for EPSDT services. Plaintiffs have requested injunctive relief and monetary damages. The monetary damages claim is based solely on the allegedly arbitrary reduction of day treatment from six (6) hours to three and a half (3.5) hours.

The individual defendants are Mr. Knickrehm, current Director of ADHS since January, 1999; Mr. Hanley,

[1] Doc. Nos. 1, 76, 95, 144, 173.

Director of Division of Medical Services of ADHS from 1994 through January 6, 2003; and Mr. Jeffus, current Director of Division of Medical Services of ADHS beginning on January 6, 2003. Before becoming Director of the Division of Medical Services, Mr. Jeffus was the division's senior Assistant Director.

Defendants allege in their Motion for Summary Judgement that Plaintiffs' Third Amended Complaint should be dismissed as a matter of law because: (1) Plaintiffs have no standing to bring this action; (2) eligibility for the EPSDT program is properly based on medical necessity; (3) Peer Review Organizations ("PROs") are favored by federal law for the purpose of reviewing recommended treatment to ensure that it is, in fact, medically necessary; (4) all benefits mandated by the Medicaid Act must meet the medical necessity standard before providers and recipients are entitled to benefits as a matter of federal statutory right; (5) the prior authorization process implemented by Mr. Hanley on behalf of ADHS is a legitimate means for avoiding payment of unnecessary Medicaid costs, thereby meeting the standard of medical necessity prescribed by the Medicaid Act; (6) Plaintiffs are provided with sufficient procedural due process to challenge any decisions made as a result of the prior authorization process and have failed to exhaust those processes; (7) the prior authorization process through the use of PROs are rationally related to legitimate government ends of ensuring that only medically necessary services are approved, and consequently, Plaintiffs cannot demonstrate deprivation of substantive due process; and (8) Defendants Kurt Knickrehm, Ray Hanley and Roy Jeffus are entitled to qualified immunity.

In sum, Defendants contend that medical necessity is appropriate justification for making policy changes for medicaid eligibility under the State Plan. Defendants further argue that the individual capacity Defendants – Mr. Knickrehm, Mr. Hanley, and Mr. Jeffus – acted in good faith, and are immune from civil damages.

In their Supplemental Motion, Defendants contend that Plaintiffs can produce no evidence linking Defendants to the alleged misconduct of the AFMC. Finally, Defendants argue that Plaintiffs cannot produce sufficient evidence to show that the individual capacity Defendants intentionally and arbitrarily violated the Social Security/Medicaid Act ("SSMA").

II. SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate only when there is no genuine issue of material fact, so that the dispute may be decided on purely legal grounds.[2] The Supreme Court has established guidelines to assist trial courts in determining whether this standard has been met:

> The inquiry performed is the threshold inquiry of determining whether there is the need for a trial – whether, in other words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they may reasonably be resolved in favor of either party.[3]

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[2] *Holloway v. Lockhart*, 813 F.2d 874 (8th Cir. 1987); Fed R. Civ. P. 56.

[3] *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986).

The Court of Appeals for the Eighth Circuit has cautioned that summary judgment is an extreme remedy that should only be granted when the movant has established a right to the judgment beyond controversy.[4] Nevertheless, summary judgment promotes judicial economy by preventing trial when no genuine issue of fact remains.[5] This court must view the facts in the light most favorable to the party opposing the motion.[6] The Motion should be denied if, in reviewing the evidence in this light, reasonable men can differ as to the conclusions to be drawn from it.[7]

The above-cited standard has been recently applied and more fully explained by the Supreme Court in *Reeves v Sanderson Plumbing Products, Inc.*:

> The court must draw all reasonable inferences in favor of the non-moving party and it may not make credibility determinations or weigh the evidence. Thus, although the court should review the record as a whole, it must *disregard all evidence favorable to the moving party that the jury is not required to believe* . . . that is, the court should give credence to the evidence favoring the moving party that is *un-impeached, at least to the extent that the evidence comes from disinterested witnesses.*[8]

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[4] *Inland Oil & Transport Co. v. United States,* 600 F.2d 725, 727 (8th Cir. 1979).

[5] *Id.* at 728.

[6] *Id.* at 727-28.

[7] *Cargill v. Liberty Mutual Ins. Co.,* 488 F. Supp 49 (D.C. Minn. 1979), affd. 621 F.2d 275 (8th Cir. 1980); *Greenwood v Dittimer,* 596 F. Supp 235 (D.C. Ark. 1984) affd. 776 F2d 785 (8th Cir. 1985).

[8] 530 U.S. 133, 150 (2000) (emphasis added).

In other words, the Supreme Court has clearly directed that when weighing the record on summary judgment, the evidence presented by the moving party must be evaluated in a much different light than the evidence presented by the non-moving party. When considering the evidence presented by the moving party, only evidence that is presented by witnesses that a jury is obliged to believe should be taken into account – such as evidence presented by disinterested witnesses or evidence that is corroborated by independent sources. On the other hand, all evidence presented by the non-moving party is given deference.

III. DISCUSSION

A. Standing To Bring Action:

A private action against a State official to vindicate federal statutory rights is authorized by 42 U.S.C. § 1983. Whether a provision of the Medicaid Act creates enforceable procedural and substantive rights turns on whether the provision was intended to benefit a plaintiff. If so, an enforceable right is created unless, it merely reflects a congressional preference for a certain kind of conduct rather than a binding obligation on the governmental unit; or unless the interest the plaintiff asserts is "too vague and amorphous such that it is beyond the competence of the judiciary to enforce."[9]

Medicaid is a joint federal-state program that provides medical care to low-income individuals. Beneficiaries of the

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[9] *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 509 (1990).

program are the aged, blind, and permanently disabled.[10] Beneficiaries have also been found to include care givers. In *Wilder,* the Supreme Court held that a specific provision of the Medicaid Act created enforceable substantive rights for institutional health care providers, as well as for the aged, blind, and impaired.[11]

The Medicaid Act sets out a list of sixty-five (65) items that must be contained within a valid state plan.[12] One such item is the so-called "equal access" provision:

> [A State plan for medical assistance must] provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as maybe necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and *are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.*[13]

The Eighth Circuit considered whether the *Wilder* rationale also applied to the above-cited equal access provision. The court found that the SSMA created substantive enforceable rights under § 1983 with respect to the equal access provision.[14] Moreover, in *Reynolds,* the

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[10] *See* 42 U.S.C. § 1396 et seq.; *Wilder,* 496 U.S. at 502.

[11] *Wilder*, 496 U.S. at 520.

[12] *See* 42 U.S.C. § 1396a(a) subsections(1) through (65).

[13] 42 U.S.C. § 1396a(a)(30) (Emphasis added).

[14] *Arkansas Med. Soc'y, Inc. v. Reynolds,* 6 F.3d 519, 525 (8th Cir. 1993), citing *Wilder*, 496 U.S. at 512. ("[T]he equal access language 'sets

(Continued on following page)

court determined that recipients *and* health care providers were intended beneficiaries under the equal access provision, since health care providers, as payees, obviously are affected by substantive changes in state schemes under Medicaid.[15]

The same conclusion was reached in *Pediatric Specialty Care et at v. Arkansas Department of Human Services, et al.*,[16] where the Eighth Circuit held that Plaintiffs in the present case properly asserted federal rights enforceable in a § 1983 action. The court found that substantive statutory rights enforceable by § 1983 were created with respect to EPSDT benefits as a whole and specifically, with respect to entitlements in § 1396d(a)(6) and § 1396d(a)(13).[17] The Eighth Circuit held "that a Medicaid-eligible individual has a *federal right* to early intervention day treatment when a physician recommends such treatment."[18]

In sum, plaintiffs who care for eligible children, along with the children themselves, have enforceable § 1983 rights. Therefore, whether the providers and recipients in this case have standing as beneficiaries to bring this action has been settled by the Eighth Circuit.[19] In fact, the court made it clear that both recipients and providers are

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forth a congressional command which is wholly uncharacteristic of a mere suggestion or nudge.' ").

[15] *Reynolds*, 6 F.3d at 526-28 (emphasis added). *See also Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1295 (8th Cir. 985); *Oklahoma Nursing Home Ass'n v. Demps*, 792 F. Supp. 721, 727 (W.D. Okla. 1992).

[16] 293 F.3d 472, 487 (8th Cir. 2002).

[17] *Id.* at 480.

[18] *Id.* (emphasis added).

[19] *Id.*

intended beneficiaries of the EPSDT services as defined by § 1396d as well as § 1396a.[20] The court also pointed out that "even without individual standing, the provider plaintiffs in this case have standing to assert the rights of their CHMS patients."[21] All Plaintiffs in this case may seek redress for any alleged violation of substantive statutory rights created by the Medicaid Act. Therefore, the threshold basis of standing is met.

B. Standing to Assert an Interest in the Litigation:

In addition to contending that the medical providers are not beneficiaries of the equal access provision, Defendants argue that Plaintiffs have failed to allege, or present evidence of sufficient injury. In order to meet the constitutional standing requirement, Plaintiffs must suffer an injury-in-fact that is an invasion of a legally protected interest – one that is concrete and particularized.[22] The injury-in-fact requirement serves to distinguish a person with a direct stake in the outcome of a litigation – even though small – from a person with a mere interest in the problem.[23]

Plaintiffs allege that Defendants invaded a legally protected interest that is concrete, to which they are its

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[20] *Id.*

[21] *Id.* (*citing Singleton v. Wulff*, 428 U.S. 106, 115-17 (1976)).

[22] *Republican Party of Minn., Third Congressional Dist. v. Klobuchar*, 381 F.3d 785, 791 (8th Cir. 2004).

[23] *United States v. Students Challenging Regulatory Agency Procedures*, 412 U.S. 669, 689 n. 14 (1973).

beneficiaries – entitlement to EPSDT benefits. Furthermore, Plaintiffs have more than a "mere interest in the problem." The denial of this federal entitlement results in loss to providers and recipients alike. The evidence indicates that providers have lost significant revenue as a result of an allegedly unlawful prior authorization process; and recipients have been deprived of services crucial to their medical needs.[24]

Finally, Defendants contend that Plaintiffs lack standing because Plaintiffs cannot show that they made individual administrative claims challenging the medical necessity determinations at the state level. However, the existence of administrative procedures where health care providers and medicaid recipients can obtain review of individual claims for payment does not foreclose a private remedy in the federal courts through § 1983.[25]

In sum, the record offers sufficient evidence that Plaintiffs have standing to bring the current action. The fact that Plaintiffs can challenge denials through a state administrative process is irrelevant to their right to seek redress under § 1983 – especially when the denial of benefits is as sweeping as has allegedly occurred in this case.

C. Medical Necessity:

The remainder of Defendants' contentions are based on the standard of "medical necessity." Defendants argue

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[24] Plaintiffs' original Response Ex. P, affidavit of Dr. Sharon Ramy.

[25] *See Patsy v. Board of Regents of Fla.*, 457 U.S. 496, 516 (1982); *Wilder*, 496 U.S. at 523.

that the state has the discretion to limit the scope of eligibility based on medical necessity of prescribed care. Moreover, Defendants assert that PROs, such as the Arkansas Foundation for Medical Care (AFMC), are an appropriate vehicle through which prescribed treatments may be reviewed for compliance with medical necessity. Defendants assert that any changes implemented through the prior authorization process are consistent with the mandate of the SSMA – to provide only those services that are medically necessary. Finally, Defendants argue that the prior authorization process is within the realm of state authority; and is legitimately based solely on considerations of medical necessity. Defendants vigorously deny improper motive behind the changes.

The state has the right to place limits on treatment based on medical necessity. However, the boundaries of state discretion are limited by the rules and regulations of the Medicaid Act. The state's authority and limitations are addressed in several opinions handed down by the Eighth Circuit, beginning with the role of the treating physician and weight given his opinions:

> "[t]he Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment."[26] However, while there is a presumption in favor of the treating physician, the regulations make it clear that treating physicians are not the sole arbiter of medical necessity.

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[26] *Pinneke v. Preisser*, 623 F2d 546, 549 (8th Cir. 1980); *Smith v. Rasmussen*, 249 F.3d 755, 759 (8th Cir. 2001).

There is no question that the Medicaid Act confers broad discretion on the states to adopt standards for determining the extent of needed medical assistance.[27] Indeed, the Department of Health and Welfare regulations read: "The agency may place appropriate limits on services based on such criteria as medical necessity."[28] As the Eighth Circuit has concisely pointed out Medicaid was designed "to provide the largest number of necessary medical services to the greatest number of needy people."[29] However, any medical necessity standards adopted by the state must be *"reasonable"* and *"consistent with the objectives of the Act."*[30] Further, the Medicaid Act mandates that a provided service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose."[31] Medical necessity determinations must be consistent with the overall goal of the recommended treatment and the objectives of the program – to provide appropriate care that achieves maximum reduction of impairment. Thus, the Act and its regulations both protect and limit a state's discretion to define the scope of necessary coverage.[32]

It should also be noted that Plaintiffs challenge agency prior authorization guidelines that affect the medical care of large categories of impaired children. This is distinct from case-specific determinations of medical necessity. The Supreme Court has indicated that "serious

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[27] *Smith*, 249 F.3d at 759.

[28] 42 C.F.R. § 440.230(d).

[29] *Ellis v. Patterson*, 859 F.2d 52, 55 (8th Cir.1988).

[30] *Beal*, 432 U.S. at 443 (emphasis added).

[31] 42 C.F.R. § 440.230(b).

[32] *Rasmussen*, 249 F.3d at 759.

statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its *coverage.*"[33] Plaintiffs' allegations suggest that Defendants are using the medical necessity standard as justification for what is, instead, a *de facto* coverage exclusion. The Eighth Circuit recently made it clear that decisions to eliminate components of the CHMS program would result in a substantial change to the level of payment for services mandated by the Medicaid Act.[34]

Following *Beal*, the Eighth Circuit wrote an exhaustive analysis of the "medical necessity" standard in *Hodgson v. Board of County Commissioners, County of Hennepin.*[35] In *Hodgson*, the court found that, once a state designates services that it will provide, the state may make eligibility decisions only on the basis of individual need. The court held that the only time a state could make sweeping exclusions of a medical procedure were when the procedure is "never, or generally never, of sufficient medical necessity."[36]

The court said that a state may reasonably modify its eligibility requirements and medically necessary services. However, the restrictions must be consistent with the degree of a *recipient's* medical needs.[37] The court further held that within the category of "medical necessity" the scope of review must be in accordance with the Medicaid

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[33] *Beal v. Doe*, 432 U.S. 438, 444 (1977) (emphasis added).

[34] *Pediatric Specialty Care, Inc. et al. v. Arkansas Department of Human Services et al.*, 364 F.3d 925 (8th Cir. 2004).

[35] 614 F.2d 601, 608-10 (1980).

[36] *Id.* at 608.

[37] *Id.* at 610-611 (emphasis added).

Act – to provide medical assistance in the *best interest of* the recipient and on an even-handed basis.[38] The court also held that eligibility determinations based on type of condition, illness, or diagnosis are never reasonable. By way of example, the Eighth Circuit explained that a state may *not* choose to provide eyeglass subsidies for only those persons whose poor vision is from an eye disease, even though the state considers them most needy. In other words, simply because a child from a poor family suffers from a serious eye disease, he is not any more eligible for eye glasses than one who is simply near-sighted. The question, and basic criterion, is whether each child needs the corrective therapy.[39] The regulations permit discrimination in benefits based upon the degree of medical necessity, but not upon the extent of medical disorders from which the person suffers.[40] Likewise, Defendants argue that because the CHMS day treatment clinics must provide multi-disciplinary care to address the needs of the most seriously impaired children, i.e., those who need a variety of therapies – then children who need day treatment, but are not so seriously impaired, should be excluded from coverage. Again, this ignores the basic criterion –whether the child needs day treatment corrective therapy to ameliorate his disability. Finally, the Eighth Circuit has also held that state schemes based *solely* on budget concerns are invalid.[41]

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[38] *Id.* (emphasis added).

[39] *Id.* at 608 (*citing White v. Beal*, 555 F.2d 1146, 1150-52 (3d Cir. 1977)). *See also* 42 C.F.R. § 230(c).

[40] *See Pinneke*, 623 F.2d at 550.

[41] *Reynolds*, 6 F.3d at 522, 531 (emphasis added).

As stated above, under the above regulations and precedent, the actions of the state with respect to benefits must be reasonable and consistent with the objectives of the Medicaid Act. Medical necessity determinations must be geared to the medical need of the recipient. The opinion of the treating physician is given reasonable deference. Any coverage denial cannot be based legitimately on the diagnosis of the recipient or on budget concerns. In 1967, Congress amended the Medicaid Act to provide EPSDT services to medicaid eligible children. The stated objective of these services is to facilitate the maximum reduction of physical or mental disability, and restore a child to the best possible functional level. The state plan must provide medically necessary services that reasonably meet this objective. Finally, Plaintiffs' allegations raise a legitimate legal and factual question that is material to this case: to wit, are Defendants denying *coverage* to a large segment of eligible children under the rubric of "medical necessity?" I have already held that any reduction in services that is applied to *all* children without consideration of an individual child's diagnosed medical condition, and prescribed treatment and the accumulated knowledge of the medical community would run afoul of the Medicaid Act.[42]

Here, Defendants have provided information from administrators of the ADHS and the AFMC to show that medical necessity is the sole guiding principle by which eligibility for CHMS is determined.[43] These same administrators offer additional testimony that authorization of

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[42] Doc. No. 150, p. 13.

[43] Affidavits of Ray Hanley (Defendants' Exhibit 4); Roy Jeffus (Defendants' Exhibit 5); Marilyn Strickland, Utilization Review Administrator for the Division of Medical Services (Defendants' Exhibit 6); Dr. Michael Moody, Medical Director for AFMC (Defendants' Exhibit 7)

CHMS services is case specific; is based on the opinions of qualified independent physicians; and is based reasonably on the legitimate need of each medicaid eligible child.[44] In short, Defendants present testimony from its own administrators that the ADHS has limited the scope and duration of services in a manner which complies with the overall objectives of the medicaid act and the EPSDT provisions. However, under the *Reeves* holding, this is not evidence that a fact finder is necessarily obliged to believe.[45]

D. Budget Concerns versus Medical Necessity:

On the other hand, Plaintiffs have provided evidence from which a reasonable fact finder could draw conflicting conclusions – beginning with the original notice announcing the intentions of Mr. Hanley to modify the scope of medicaid coverage.[46] The notice reveals that the proposed changes would provide a significant decrease in medicaid expenditure. Addressing cost benefits, together with a notice of proposed changes in medicaid eligibility, creates a reasonable inference that the proposed modifications were motivated by financial concerns. As pointed out above, this, standing alone, is not a legitimate basis for limiting eligibility or the scope and duration of required services. "A state may not flout the Medicaid Act's requirements in order to suit state budgetary needs."[47] In affirming the

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[44] Defendants' Motion for Summary Judgment Exs. 2-8.

[45] *Reeves*, 530 U.S. at 150.

[46] Plaintiffs' original Response, Ex. A.

[47] *Arkansas Medical Soc., Inc. v. Reynolds*, 819 F. Supp. 816, 824 (E.D. Ark. 1993) *(citing Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 398 (5th Cir. 1980).

District Court, the Eighth Circuit found that persuasive precedent supports the proposition that budgetary considerations cannot be the conclusive factor in decisions regarding Medicaid.[48] The *conclusive* factor in rate determination *must not be* the amount of money appropriated by a given state's legislature; rather the state Medicaid agency must make an objective, principled decision regarding what is reasonable and adequate to meet the needs of medicaid beneficiaries.[49]

E. Medical Needs of Individual Recipients:

Plaintiffs offer additional evidence that a decrease from six (6) hours to three and a half (3.5) hours per day of treatment services is applied generally, without any specific investigation as to individual recipients; or the effect such a reduction has on equal access to quality care. For instance, not one of the reviewing physicians could provide an example when more than three and a half (3.5) hours of day treatment were approved. Moreover, none of these physicians offered a reasonable medical foundation for the reduction in the scope and duration of intervention therapies offered by CHMS clinics.[50] Plaintiffs presented Dr. Sharon Ramey, an expert in the field of pediatric developmental disabilities, who testified that the most

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[48] *Arkansas Medical Soc., Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993).

[49] *Illinois Hosp. Ass'n v. Illinois Dept. of Public Aid* 576, F. Supp. 360, 368 (D.C. Ill.1983).

[50] Dr. Whitaker (Plaintiffs' original Response Ex. G, p. 39); Dr. Tracey Steward (Plaintiffs' original Response Ex. H, p. 58); Dr. H. Frazier Kennedy (Plaintiffs' original Response Ex. K, pp. 25-26); Dr. Susan Keathley (Plaintiffs' original Response Ex. L, p. 33).

effective manner of achieving maximum improvement for impaired children includes intervention therapies lasting at least six (6) hours each day.[51] Therefore, Plaintiffs have raised an inference that Defendants have violated 42 C.F.R. § 440.230(b), which requires that "each service *must* be sufficient in amount, [and] duration . . . to reasonably *achieve its purpose*."[52] As Defendants are well aware, the stated purpose for EPSDT services, including day treatment, is to provide treatment for the maximum reduction of physical and mental disability.

F. Eligibility based on Single Impairment Diagnosis:

Defendants have created guidelines where a child with a malady that creates a single impairment – requiring only one type of therapy such as speech therapy, physical therapy, etc. – is not prior authorized for CHMS services, despite the severity of the impairment. Plaintiffs have produced evidence indicating that this "prior authorization" guideline has excluded large numbers of children from EPSDT services, discouraging providers from making additional attempts to obtain EPSDT services for such children.[53] Such a policy may well violate the requirement set forth in 42 C.F.R. § 440.230(c) which reads: "The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of required services . . . to an otherwise eligible recipient solely because of the

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[51] Plaintiffs' original Response Ex. P, pp. 8-14.

[52] 42 C.F.R. § 440.230(b) (emphasis added).

[53] Plaintiffs' original Response Ex. C, Ex. H, p. 42; Ex. G, p. 25.

diagnosis."[54] Defendants justify this guideline by asserting that the CHMS provider manual, prepared by ADHS, describes CHMS services as multi-disciplinary. I am not persuaded that the term "multi-disciplinary" is sufficient justification for denying required medicaid services to eligible children. Such a rationale – that only those children who are afflicted with the most serious conditions are entitled to medicaid benefits – was rejected by the Third Circuit.[55] More importantly, there is nothing in the Medicaid Act which limits EPSDT services to only children with a need for two or more intervention therapies. Therefore, the across-the-board denial of CHMS day treatment services to children with a single impairment raises a reasonable inference that children are being denied their right to EPSDT services because of their disorder without consideration of individual medical need. As the court in *Pinneke* made clear, this is an improper basis for the denial of a statutory right.[56] Moreover, a recent opinion issued by the Fifth Circuit strongly advised that EPSDT services cannot, under any circumstances, be limited by state plans. Citing to several other circuit decisions, including the Eighth Circuit opinion issued in the present case, the Fifth Circuit held:

> Congress did not allow states the discretion to define what types of health care and services would be provided to EPSDT children, and that participating states must provide all services within the scope of §1396d(a) which are necessary to correct

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[54] *See also Pinneke*, 623 F.2d at 550.

[55] *White v. Beal*, 555 F.2d at 115.

[56] *Pinneke*, 623 F.2d at 550.

defects, illnesses, and conditions in children discovered by the screening services.[57]

In the *Dickson*, the Fifth Circuit unequivocally stated that the states have very little discretion with regard to the EPSDT provisions: "We reject the notion that Congress made the provision of [EPSDT] treatment mandatory on the states only to cede to the states complete discretion to decide upon the contents of the medical assistance programs available to EPSDT eligible children."[58] The Fifth Circuit held that the twenty seven categories of medical assistance outlined in the EPSDT provisions are not "empty vessels" to be filled according to the state's discretion.[59] The court emphasized that the state must provide all assistance that is necessary to treat or ameliorate conditions in children discovered by the screening process.[60]

The evidence strongly indicates that Defendants, by denying EPSDT services to children in need of only one type of therapy, have exceeded their boundaries in the exercise of their responsibilities under the Medicaid Act.

G. Alleged Misconduct within the Prior-Authorization Process:

Plaintiffs filed a supplemental response to Defendants' Motion for Summary Judgment. Plaintiffs' supplemental response presents the testimony of Ms. Brenda Gassaway,

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[57] *S.D. Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004).

[58] *Id.* at 592.

[59] *Id.*

[60] *Id*

a nurse and former employee of AFMC; and Dr. Whitaker, a board certified pediatrician and contract physician for AFMC. The sworn statements of both these witnesses, if accepted by the trier of fact, implicate the ADHC and the AFMC in widespread abuses that demonstrate a disregard for the medical needs of eligible children as well as a disregard for the objectives of the Medicaid Act, the Orders of this Court, and the Circuit Court.

Ms. Gassaway was employed at AFMC for four years, reviewing charts for personal care, targeted health management, and child health management programs.[61] In January 2002, Ms. Gassaway discovered that another nurse reviewer, Ms. Tilerra Coates, had altered files by overriding opinions of reviewing physicians and reducing the scope and duration of approved treatment.[62] Ms. Gassaway immediately reported the discrepancies to the department manager, Ms. Amy Carson, who is also a nurse. Thereafter, Ms. Gassaway began to monitor Ms. Coates's charts, and made frequent reports to Ms. Carson concerning discovered alterations that contravened physician opinions and recommendations.[63]

Ms. Gassaway identified several codes that were singled out by general policy and by Ms. Carson that could not be approved under any circumstances.[64] According to Ms. Gassaway, the AFMC also developed a system of

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[61] Plaintiffs' Supplemental Response Ex. B, p. 8

[62] Plaintiffs' Supplemental Response Ex. B, pp. 12-16.

[63] Plaintiffs' Supplemental Response Ex. B, pp. 16-18.

[64] Plaintiffs' Supplemental Response Ex. B, pp.19-20.

canned denials[65] referred to as "one minute charts."[66] The nurse reviewers are allowed to enter the canned denials that then turned over to Dr. Whitaker for signature. Ms. Gassaway began to monitor Ms. Coates's charts and discovered that eighty percent (80%) of the "one minute" charts were altered. Although Ms. Gassaway frequently brought these improprieties to Ms. Carson's attention, nothing was done.[67]

The existence of the canned denials were disclosed to separate Defendant AFMC counsel, Mr. Mike Rainwater. Ms. Gassaway testified that Mr. Rainwater advised the nurses "not to bring up" the use of canned denials during the course of their depositions.[68] Ms. Gassaway testified that there were no in house guidelines *per se*, but that each nurse reviewer received frequent memos from Ms. Carson identifying what services could and could not be approved.[69] Ms. Gassaway was told by her supervisors, Ms. Kenya Harkin and Ms. Carson, that cost savings was the only basis for renewal of the contract between AFMC and ADHS. Ms. Gassaway indicated that cost savings was the primary incentive for decisions made by AFMC, and further testified that the ADHS required monthly cost savings reports.[70] Ms. Gassaway described her general observations of the internal workings of AFMC in the following manner: "I worked there for four years and I saw

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[65] Canned denials are rote rationales used when authorization for certain designated services are routinely denied.

[66] Plaintiffs' Supplemental Response Ex. B, pp. 17-19.

[67] Plaintiffs' Supplemental Response Ex. B, p. 18.

[68] Plaintiffs' Supplemental Response Ex. B, pp.18-19.

[69] Plaintiffs' Supplemental Response Ex. B, p. 21.

[70] Plaintiffs' Supplemental Response Ex. B, pp. 33-35.

the patterns of how the programs are worked and it seems like the goal is always to cut services and to make the centers jump through hoops to get the kids approved, so that they will just quit."[71] Ms. Gassaway went on to describe various practices that she observed including capping the scope and duration of recommended services; and making constant changes in authorization criteria.[72]

Ms. Gassaway described the response of AFMC administrators to complaints lodged since January 2002 concerning Ms. Coates' alteration of physician recommendations: "Hide it, get rid of the people that know, lock it up, deny access, cover it up."[73]

When asked about the truthfulness of Dr. Moody's testimony with respect to the assistance given by AFMC to CHMS providers, Ms. Gassaway offered the most stark statement in her deposition: "No, that was not the truth. *The truth is no matter what they ask for you don't give it to them ever until they beg for it* . . . That's the truth."[74]

With respect to the involvement of the ADHC in the decision making processes of AFMC, Ms. Gassaway indicated that Ms. Wilson and Ms. Strickland, both Directors of Utilization for the ADHC, frequently directed Ms. Carson to deny generally the duration and scope of certain recommended services. Ms. Gassaway indicated that when she first began working for AFMC, several memos were issued containing directives from Ms. Wilson, via Ms.

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[71] Plaintiffs' Supplemental Response Ex. B, p. 36.

[72] Plaintiffs' Supplemental Response Ex. B, pp. 36-37.

[73] Plaintiffs' Supplemental Response Ex. B, p. 43.

[74] Plaintiffs' Supplemental Response Ex. B, p. 22 (emphasis added).

Carson.[75] Finally, Ms. Gassaway stated that Mr. Rainwater and Mr. Hopkins, counsel for ADHC and AFMC, were aware of the "one minute" charts and the use of canned denials.[76]

Dr. Whitaker is the only board certified pediatrician working with AFMC. Dr. Whitaker corroborated the testimony of Ms. Gassaway. He stated that he also audited the files and discovered alterations made by Ms. Coates on a large percentage of the "one minute charts." Like Ms. Gassaway, Dr. Whitaker brought this to the attention of Ms. Carson, yet no action was taken.[77] Most of the changes made by Ms. Coates involved the reduction of services for particular codes.[78] Dr. Whitaker also reported the discrepancies to the medical director of AFMC, Dr. Moody, and to other physicians, including Dr. Keathley.[79]

Dr. Whitaker admitted that he was the author of the "canned denials" and that they were composed at the request of Ms. Carson. After the canned denials were created, nurse reviewers were allowed to apply them at their discretion. The canned denials were used to save time and money. The nurse reviewers never received formal training in the proper application of the canned denials.[80] Dr. Whitaker testified, as did Ms. Gassaway, about AFMC practices that intentionally made the application and authorization process as difficult as possible.[81] Dr. Whitaker summarized his complaints:

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[75] Plaintiffs' Supplemental Response Ex. B, pp. 38-39.

[76] Plaintiffs' Supplemental Response Ex. B, p. 45.

[77] Plaintiffs' Supplemental Response Ex. E, pp. 8-18.

[78] Plaintiffs' Supplemental Response Ex. E, p. 22.

[79] Plaintiffs' Supplemental Response Ex. E, pp. 30-31.

[80] Plaintiffs' Supplemental Response Ex. E, pp. 52-55.

[81] Plaintiffs' Supplemental Response Ex. E, pp. 68-69.

> I made the decision . . . it's been altered . . . the child services have been reduced, which hurts the child . . . that's what bothers me . . . my driving force is . . . to serve these kids like they need to be served . . . I don't like it when what I've done has been changed and child services reduced . . . I certainly don't like it when rationales that I have done turn up missing from the chart.[82]

Dr. Whitaker testified that he was always told to deny services for a child with only one diagnosis, that he was to look for two qualifiers, and that units of recommended services were capped despite guidelines to the contrary.[83]

Like Ms. Gassaway, Dr. Whitaker testified that directives were given to Ms. Carson from the ADHS through Ms. Marilyn Strickland – Ms. Wilson's successor.[84] When asked why he has not resigned, Dr. Whitaker responded that if he leaves "things would only get worse."[85]

In view of the above referenced testimony, together with the voluminous documentation offered in support, there remains a question of fact as to whether Defendants, through its authorized PRO and the application of the prior authorization process – are providing services mandated by federal law and the Constitution. The testimony creates genuine issues from which a reasonable inference could be drawn that AFMC engaged in arbitrary, capricious, and unreasonable conduct designed to deny

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[82] Plaintiffs' Supplemental Response Ex. E, p. 89.

[83] Plaintiffs' Supplemental Response Ex. E, pp. 75-77, 89-92.

[84] Plaintiffs' Supplemental Response Ex. E, pp. 77, 100-01.

[85] Plaintiffs' Supplemental Response Ex. E, p. 104.

EPSDT services to qualified recipients, violating the objectives of the Medicaid Act in general, and the equal access clause in particular. Plaintiffs provide sufficient evidence from which an inference may be drawn that Defendants' certified PRO – AFMC – failed to give proper deference to the recommendations of treating physicians; failed to ensure that medical reviews are performed by qualified independent physicians; failed to ensure that reviews are based on reasonable medical standards; denied authorization for services based upon diagnosis alone; and limited the duration and scope of recommended services without reasonable cause, solely for budget concerns. In short, the evidence raises the inference that AFMC limited the amount of certain services for all children, regardless of the severity of their delays; and without consideration of a child's diagnosed condition and prescribed treatment, and the accumulated knowledge of the medical community. The testimony further creates the inference that Defendants Ray Hanley and Roy Jeffus were not only aware of the practices, but also given incentives and rewarded for their practices by maintaining its contract with AFMC.

There is testimony that administrative officers with the ADHC issued verbal directives to the AFMC to cap services across the board with respect to certain recommended treatment codes. These officers were in charge of utilization for the Department of Medical Service – Ms. Marilyn Strickland and Ms. Sharon Wilson. There is further testimony that Defendants' attorneys, Mr. Hopkins and Mr. Rainwater, were aware of the existence of the utilization of "canned denials" and the "one minute reviews." There is evidence that monthly cost reports and the ability of AFMC continuously to reduce cost by

reducing services was the sole basis for AFMC's contract with the State.

Defendants assert that Plaintiffs are merely complaining that their rights are being violated because they are subject to federally mandated medical necessity criteria. But Plaintiffs have produced sufficient evidence creating an inference that the criteria utilized by Defendants is not based on reasonable medical necessity determinations. Rather, Plaintiffs complain that Defendants violated federal laws by unreasonably depriving eligible children of benefits to which they were entitled.

In their Supplemental Motion for Summary Judgement, Defendants assert that the testimony of Ms. Gassaway and Dr. Whitaker does not render the state defendants liable. Defendants assert that the testimony of these two witnesses shows that a rogue nurse – Ms. Coates – engaged in unsanctioned misconduct. However, for all the reasons set forth above, the testimony of Ms. Gassaway and Dr. Whitaker raise questions that go far beyond Ms. Coates's activities.

H. Procedural Due Process:

Defendants contend that Plaintiffs have not identified a protected property interest entitled to due process protection. This issue was settled by the Eighth Circuit, which held "We find it entirely appropriate for Plaintiffs to base their procedural due process claim on their clearly established right to have equal access to quality medical care as defined by § 1396(a)(30)(A)."[86] The Eighth Circuit

[86] *Pediatric*, 364 F.3d at 930.

instructed Defendants to complete a proper study to insure that factors such as quality of care and equal access are not jeopardized by changes in the methods and procedures for payment of these mandatory services.[87] Moreover, in their earlier opinion, the Eighth Circuit found that §1396d(a)13 creates a federal right to day treatment prescribed by a treating physician.[88]

There is no question that Plaintiffs have provided sufficient evidence from which an inference can be drawn that Defendants have failed to follow the directives of this Court and the Court of Appeals. Defendants engaged in undisclosed practices that jeopardized the ability of eligible children to obtain equal access to quality care and to medically necessary day treatment services. Plaintiffs have offered additional evidence that may lead to the conclusion that the prior authorization process is arbitrarily used with the intent of eliminating all CHMS services. The practices of AFMC as described by Ms. Gassaway raise questions about the willingness of Defendants to comply with my last directive: "Nor may Defendants bury requirements or standards for various services so that providers are unable to comply with those requirements."[89]

Defendants contend that the administrative procedures available to Plaintiffs are more than sufficient to protect the rights of the providers and beneficiaries. They also contend that the remedies provided by the state should have been exhausted before Plaintiffs filed the current action. This is not the law. "The availability of

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[87] *Id.*

[88] *Pediatric*, 293 F.3d at 480-81.

[89] Doc. No. 150, p. 13.

state administrative procedures . . . does not foreclose resort to § 1983."[90] Moreover, § 1983 relief is not precluded by the failure to exhaust state administrative and judicial remedies.[91]

Plaintiffs, therefore, have a property interest in the provision of quality care equal to that of the general population. Plaintiffs are not required to seek redress for the denial of this interest by exhausting state remedies. Instead, Plaintiffs may appropriately file a § 1983 action alleging the denial of their Constitutional right to procedural due process. However, a consideration of the state administrative process provided to medicaid recipients is clearly part of the analysis of any due process issue.

It is well established that a possessory interest in property invokes procedural due process, consisting of two crucial elements: (1) adequate notice; and (2) a meaningful hearing. Both elements must be met before depriving an individual of his property right.[92] The Supreme Court's definition of adequate notice is "notice [that is] reasonably calculated, under all circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections."[93] The Supreme

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[90] *Wilder*, 496 U.S. at 523.

[91] *See Monroe v. Pape*, 365 U.S. 167,183 (1961) ("The federal remedy is supplementary to the state remedy, and the latter need not be first sought and refused before the federal one is invoked."); *See also Greenstein by Horowitz v. Bane*, 833 F. Supp. 1054, 1068 (S.D.N.Y., 1993).

[92] *Thomas v. Cohen*, 304 F.3d 563, 576 (6th Cir.2002) (citing *Fuentes v. Shevin*, 407 U.S. 67, 87 (1972)); *See also Mathews v. Eldridge*, 424 U.S. 319 (1976) (Holding that a claim of entitlement to social security benefits triggers due process protection).

[93] *Mullane v. Cent. Hanover Trust Co.*, 339 U.S. 306, 314 (1950).

Court further clarified the standard for adequate notice in *Goldberg v. Kelley*,[94] when it required that notice be reasonably calculated to inform the recipient of the action to be taken; and to also provide an effective opportunity to be heard.

Plaintiffs in this case have presented sufficient evidence from which it may be inferred that Defendants are responsible for establishing guidelines in violation of these constitutional standards. There is additional evidence from which an inference may be drawn that internal procedures that were designed to further hinder Plaintiffs rights to quality care were formulated with the cooperation and tacit approval of Defendants.[95] Finally, Plaintiffs have provided evidence that Defendants failed to notify medicaid beneficiaries that canned denials formulated by AFMC replaced individualized medical necessity reviews. It is reasonable to assume that Plaintiffs would have wanted an opportunity to be heard on these matters.[96] The failure to disclose this conduct represents a basis for Plaintiffs' procedural due process claim. The Sixth Circuit recently found that medicaid recipients had been denied due process because beneficiaries were not given clear indication of the reason for denial. Moreover, the Sixth Circuit noted that procedures were utilized that were designed to delay and complicate the review process in a

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[94] 397 U.S. 254 (1970).

[95] *See* Plaintiffs' Supplemental Response Ex. B, pp. 22, 36-38.

[96] *See* Plaintiff's Original Response, Ex. C – Affidavit of Melissa Thomas.

manner that is very similar to the evidence presented here.[97]

Plaintiffs also assert a violation of due process based on Defendants' refusal to identify and compel the testimony of physicians and any other individuals responsible for making eligibility decisions. The power of the subpoena as well as the ability to gather evidence is an intricate part of the right to a "meaningful hearing." Citizens must be able to compel the testimony of material witnesses and to have access to all relevant evidence.[98] However, my recent decision enjoining Defendants from non-disclosure of the names of physicians and other individuals responsible for making eligibility decisions has rendered this part of Plaintiffs' due process claim moot. Based on this interpretation of the pertinent provision of the Medicaid Act, recipients may compel the testimony of each member of the PRO responsible for adverse decisions. Accordingly, recipients may compel such testimony and request relevant evidence in connection with state administrative hearings.[99]

I. Substantive Due Process:

The Eighth Circuit addressed the issue of substantive due process in its second opinion addressing this case and found that "issues may come to light as to whether cutting CHMS services would result in a substantive due process

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[97] *Hamby v. Neel*, 368 F.3d 549, 560-61 (6th Cir. 2004).

[98] *See United States v. Valenzuela-Bernal*, 458 U.S. 858, 867 (1982); *Wright v. Lockhart*, 854 F.2d 309, 312 (8th Cir.1988).

[99] Doc. No. 249.

violation."[100] It was further held by the court that this is not a case involving "fundamental rights." Thus, Plaintiffs must demonstrate either that Defendants' actions are not rationally related to legitimate government ends or that Defendants' conduct deprived Plaintiffs of their right to EPSDT services and to equal access to medicaid benefits in a manner that would "shock the conscience."

The core of the substantive due process is protection against arbitrary action and against the exercise of power without any reasonable justification in the service of a legitimate governmental objective. It is conduct that is intended to injure in some way, and that is unjustifiable by any government interest. The threshold question in a due process challenge to abusive conduct by a state actor is "whether the behavior of the governmental officer is so egregious, so outrageous, that it may fairly be said to shock the contemporary conscience."[101]

Plaintiffs have presented sufficient evidence from which it can reasonably be inferred that Defendants engaged in conduct that violated Plaintiffs' right to substantive due process. The Eighth Circuit reminded the ADHS that it was bound to provide CHMS services under the Medicaid Act, and cannot legitimately avoid its responsibility without ensuring that its conduct does not adversely affect Plaintiffs' equal access to quality care.[102] The testimony of Ms. Gassaway and Dr. Whitaker, combined with the other

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[100] *Pediatric*, 364 F.3d at 925.

[101] *County of Sacramento v. Lewis*, 523 U.S. 832, 846, n. 8 (1998); *See also Rogers v. City of Little Rock, Ark.*, 152 F.3d 790, 796-97 (8th Cir. 1998).

[102] *Pediatric*, 364 F.3d at 932.

evidence presented, raises an inference that Defendants were aware of and encouraged the alleged denial of benefits in a manner that violated federal medicaid regulation. In sum, Plaintiffs have raised an inference that Defendants' conduct was not rationally related to a legitimate end and that the conduct also represented an unreasonable and arbitrary exercise of executive power.

J. Qualified Immunity:

Defendants Ray Hanley, Kirk Knickrehm and Roy Jeffus have plead qualified immunity. Defendants assert that they are not personally responsible for any violation of Plaintiffs clearly established rights. Qualified immunity is also known as "good faith immunity" because the underlying principle for the application of immunity to state actors is "good faith." An official will not be held liable for conduct that he could not have reasonably known was illegal, nor may such an official be held liable for actions of his subordinates without some showing of personal involvement. Therefore, in order to answer the question of qualified immunity, I must consider first whether the *rights* Defendants are alleged to have violated were clearly established at the time of the violation; and second, whether there is evidence of Defendants' personal involvement in the violations.

Government officials performing discretionary functions are shielded from liability for civil damages and are entitled to qualified immunity unless their conduct violates clearly established statutory or constitutional rights

of which a reasonable person would have known.[103] Plaintiffs must assert the violation of a federal right that a reasonable official in Defendants' position would have recognized as such a violation.[104] The right to immunity set forth in the *Harlow* opinion is a right to immunity *from certain claims,* not from litigation in general.[105] In *Harlow,* the Supreme Court held: "[W]e emphasize that our decision applies only to suits for civil *damages.*"[106] The claims to which Defendants have a right to immunity are only those claims for civil damages. In this case Plaintiffs have claimed civil damages for violation of a federal statute, not for violation of a constitutional right to due process.

I am aware that Plaintiffs have requested punitive damages in each count of their complaint – particularly with regard to alleged due process violations. However, Plaintiffs failed to request actual or compensatory damages for any due process violations. Generally speaking, compensatory damages are a prerequisite to punitive damages.[107] The U. S. Supreme Court has found that due process violations are not a basis for presumed damages, but can support claims for nominal damages.[108] Plaintiffs have failed to assert any actual injury or request even nominal damages in connection with the due process violations alleged. The Supreme Court has explained that

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[103] *Harlow v. Fitzgerald,* 457 U.S. 800, 818 (1982); *Samuels v. Meriwether,* 94 F.3d 1163, 1166 (8th Cir. 1996).

[104] *Walden v. Carmack,* 156 F.3d 861, 868-69 (8th Cir. 1998); *Audio Odyssey, Ltd. v. Brenton First Nat. Bank,* 245 F.3d 721, 737 (8th 2001).

[105] *Behrens v. Pelletier,* 516 U.S. 299, 312 (1996).

[106] *Id.* at 819.

[107] *Hale v. Ladd,* 826 S.W.2d 244 (Ark. 1992).

[108] *Carey v. Piphus,* 435 U.S. 247, 263 (1978).

§ 1983 damages should be based on general principles of tort law – including the doctrine that punitive damages must be prefaced on compensatory or actual damages.[109] In view of this, I find that the issue of qualified immunity is only applicable to the Plaintiffs' claims for actual damages.[110]

To receive qualified immunity, a government official first must prove that he was acting within his discretionary authority. A law that fails to specify the precise action that the official must take in each instance creates only discretionary authority; that authority remains discretionary however egregiously it is abused.[111] Once Defendants establish that they were acting within their discretionary authority, the burden shifts to Plaintiffs to show that Defendants are not entitled to qualified immunity.

A civil action for damages may be brought under § 1983 against anyone who – under color of state statute, regulation, or custom – deprives another of any rights, privileges, or immunities secured by the Constitution and *federal laws.* This encompasses claims based on purely statutory violations.[112] In *Harlow,* the Court acknowledged

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[109] *Memphis Community School Dist. v. Stachura,* 477 U.S. 299, 308 (1986).

[110] Any other claims for punitive damages, that are made without allegations of actual injury, and a request for compensation for the injury, are without substantial merit, and need not be addressed in connection with the issue of qualified immunity.

[111] *Davis v. Scherer,* 468 U.S. 183, 196 (1984).

[112] *Maine v. Thiboutot,* 448 U.S. 1 (1980) (Holding that § 1983 creates a cause of action against state officials for violating federal statutes).

that officials may lose their immunity by violating clearly established statutory rights.[113]

For purposes of § 1983, violating "statutory rights" is separate from violation of the law itself.[114] There is no point in explaining the analytical framework concisely described in the *Reynolds* opinion. Section 1396a(a)30 (also known as the equal access provision), and § 1396d(a)13 have already been determined to create "rights" for purposes of § 1983 actions.[115] Shortly before the Eighth Circuit filed its first *Pediatric* opinion, the Sixth Circuit concluded that medicaid providers and recipients had an enforceable right to EPSDT services.[116]

The damages claims in the present action are based upon the equal access provision and, also upon § 1396d(a)13. The equal access provision has been a "clearly established" statutory right for ten years – which was so recognized in the *Reynolds* opinion handed down in a case involving the ADHS. Thus, a reasonable official in the position of Defendants should have anticipated that broad reductions in the scope and duration of medicaid services would result in legal actions.[117] The statutory right to day treatment and other

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[113] 457 U.S. at 818, n. 34.

[114] *Golden State Transit Corp., Inc. v. City of Los Angeles,* 493 U.S. 103, 106 (1989). *See Reynolds,* 6 F.3d 519 at 523.

[115] *See Reynolds,* 6 F.3d at 528 ("the equal access provision involves a federal right"); *Pediatric,* 293 F.3d at 480; ("a Medicaid-eligible individual has a right to early intervention day treatment when a physician recommends it"); *Pediatric,* 364 F.3d at 930 ("over ten years ago our court held that § 1396a(a)30 created enforceable rights for Medicaid recipients and providers").

[116] *Westside Mothers v. Haveman,* 289 F.3d 852, 863 (6th Cir. 2002).

[117] *Harlow*, 457 U.S. 818.

EPSDT services was recognized by the Sixth Circuit and the Eighth Circuit in 2002. The mandatory language of § 1396d(a)13, the medicaid regulations, and opinions from the Supreme Court and from the Eighth Circuit filed before 2002 – should have given rise to a reasonable expectation that at the time Defendants allegedly implemented broad reductions in the duration of recommended treatment, they were taking actions that would raise questions of a violation of the Medicaid Act, its regulations, and the rights that it created for physically and mentally impaired children.[118] In sum, the violations alleged by Plaintiffs were, at the time they occurred, clearly established statutory rights enforceable by § 1983. Defendants should have known that any actions adversely affecting equal access to quality care in general – and to EPSDT benefits in particular – would have legal consequences. Even if I were to determine that the right to EPSDT day treatment was not a clearly established right at the time of the alleged violation – any violation of the clearly established equal access provision is sufficient to deny qualified immunity to Defendants on this first ground.

Officials sued for violations of rights conferred by a statute or regulation become liable for damages only to the extent that there is a clear violation of the statutory rights that give rise to the cause of action for damages. If a statute or regulation does give rise to a cause of action for damages, clear violation of the statute or regulation

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[118] *See Maine v. Thiboulot, supra*; *Beal v. Doe, supra*; *Pinneke v. Preisser, supra*; *Arkansas Medical Soc'y v. Reynolds, supra*; 42 C.F.R. § 440.230(b).

forfeits immunity only with respect to damages caused by that violation.[119]

Plaintiffs alleged and have offered sufficient evidence that a second layer of the prior authorization process was implemented by the individual capacity defendants resulting in an across-the-board reduction in the scope and duration of day treatment recommended by the CHMS providers. Consequently, all medicaid eligible children were allegedly denied their full array of recommended treatment. Plaintiffs contend that this reduction has violated the equal access provision of the Medicaid Act as well as entitlement to day treatment in accordance with § 1396d(a)13. There is sufficient evidence in the record which raise a reasonable inference that the conduct of Defendants reduced the quality of care available to low income children as compared to other children in the general population. Moreover, there is sufficient evidence that costs for the additional hours of care maybe borne by the CHMS providers to such an extent that it jeopardizes the future availability of their services. Finally, according to Ms. Gassaway, elimination of such services is goal of the prior authorization practices engaged in by AFMC with the encouragement and tacit approval of Defendants.

Plaintiffs have requested damages based on the reduction in day treatment from the recommended six (6) hours of treatment per day to no more than three and a half (3.5) hours per day. Therefore, the civil damages requested by Plaintiffs arise from the alleged deprivation of statutory rights. Plaintiffs also allege that Defendants reduced the duration of early intervention treatment in an

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[119] *Davis*, 468 U.S. at 94.

arbitrary manner. As I have emphasized throughout this order – the stated purpose of early intervention day service is maximum reduction of medical and physical disabilities. As stated above, the Eighth Circuit found that a "Medicaid-eligible individual has a right to early intervention day treatment when a physician recommends such treatment."[120] The court unequivocally stated:

> If a CHMC physician prescribes early intervention day treatment as a service that would lead to maximum reduction of medical and physical disabilities and restoration of the child to his or her best possible functional level, the *Arkansas plan must reimburse the treatment.*[121]

In view of the above, Plaintiffs have alleged a violation of an established right and have requested civil damages related to the violation. There is enough evidence provided by Plaintiffs that the individual capacity Defendants should have been aware that their discretionary actions were in violation of the equal access provision of the Medicaid Act as well as provisions pertaining to rights created by § 1936d(a)(13). No reasonable official would claim to be unaware of the statutory right of medicaid recipients to equal access to quality medical care.[122] Therefore, the individual Defendants have failed to show that they are entitled to qualified immunity. This brings me to the second issue in the analysis of Defendants' entitlement to good faith immunity – the question of their personal involvement in alleged violations.

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[120] *Pediatric*, 293 F.3d 472 at 480.

[121] *Id* at 481.

[122] *Groh v. Ramirez*, 540 U.S. 551, 564 (2004); *Crawford-El v. Britton*, 523 U.S. 574, 587 (1998).

K. Vicarious Liability:

To establish personal liability in a § 1983 action, a plaintiff must show that the official, acting under color of state law, caused the deprivation of a federal right.[123] Causation cannot be based on the concept of imputed liability – there is no supervisory strict liability in § 1983 actions.[124] Supervisory officials are not liable under § 1983 for the unconstitutional acts of their subordinates on the basis of *respondeat superior* or vicarious liability.[125] Instead, for a supervisor to be held liable for the acts of a subordinate, something more must be shown than merely the existence of the supervisor-subordinate relationship must be shown.[126] Supervisory liability under § 1983 occurs either when the supervisor personally participates in the alleged unconstitutional conduct; or when there is a causal connection between the actions of a supervising official and the alleged constitutional deprivation.[127] It must be noted that personal participation is not required for liability to attach.[128]

A necessary causal connection can be established when a history of widespread abuse puts the responsible supervisor on notice of the need to correct the alleged deprivation and he fails to do so.[129] Once an official is so

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[123] *Kentucky v. Graham,* 473 U.S. 159, 160 (1985).

[124] *Harris v. Greer,* 750 F.2d 617, 618 (7th Cir.1984).

[125] *Hartley v. Parnell,* 193 F.3d 1263, 1269 (11th Cir.1999).

[126] *Hahn v. McLey,* 737 F.2d 771, 773 (8th Cir.1984) (per curiam).

[127] *Brown v. Crawford,* 906 F.2d 667, 671 (11th Cir.1990).

[128] *Wilson v. Attaway,* 757 F.2d 1227, 1241 (11th Cir.1985); *Henzel v. Gerstein,* 608 F.2d 654, 658 (5th Cir.1979).

[129] *Braddy v. Fla. Dept. of Labor & Employment,* 133 F.3d 797, 802 (11th Cir.1998).

notified, either actually or constructively, it is reasonable to infer that the *failure* to take such steps – as well as the actual *taking* of them – is a choice.[130] When supervisory liability is imposed, it is imposed against the supervisory official in his individual capacity for his own culpable choice between action or inaction in the training, supervision, or control of his subordinates.[131] In other words, the causal connection may be established where a history of widespread prior abuse puts the official on notice for the need to improve training or supervision.[132]

Alternatively, the causal connection may be established when a supervisor's custom or policy results in deliberate indifference to constitutional or statutory rights; or when the supervisor directed the subordinates to act unlawfully or knew that the subordinates would act unlawfully and failed to stop them from doing so.[133] In sum, a state official, sued in his individual capacity, can be held liable for the behavior of his subordinates if (1) the behavior of such subordinates results in a statutory violation; and (2) the officials action or inaction was affirmatively linked to the violation.[134] An affirmative link may be inferred from supervisory condonation or acquiescence which tacitly encourages conduct depriving citizens of their rights.

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[130] *Pembaur v. City of Cincinnati*, 475 U.S. 469, 483-84 (1986).

[131] *Clay v. Conlee*, 815 F.2d 1164, 1169-70 (8th Cir.1987); *Hahn*, 737 F.2d at 773.

[132] *Bowen v. Watkins*, 669 F.2d 979, 988 (5th Cir.1982). *See also Clement v. Gomez*, 298 F.3d 898, 905 (9th Cir.2002).

[133] *Rivas v. Freeman*, 940 F.2d 1491, 1495 (11th Cir.1991); *Hartley*, 193 F.3d at 1263; *see also Post v. City of Ft. Lauderdale*, 7 F.3d 1552, 1560-61 (11th Cir.1993).

[134] *See Oklahoma City v. Tuttle*, 471 U.S. 808, 823 (1985).

Plaintiffs have provided sufficient evidence from which a reasonable inference can be drawn that the individual capacity defendants, Mr. Hanley and Mr. Jeffus, implemented a policy that reduced the scope and duration of day treatment for beneficiaries of the Medicaid Act. In fact, guidelines issued by Mr. Hanley on behalf of ADHS clearly demonstrate that the policy in 1998 provided for six (6) hours per day for recommended day treatment for the following codes: 99211, 99212, Z1570, Z1571, Z1572, and Z1575.[135] However, subsequent guidelines issued to CHMS providers, reduced the time period for 99211 services to five (5) minutes; 99212 services to ten (10) minutes; and Z1575 services to one (1) hour.[136]

Drs. Whitaker, Stewart and Kennedy all testified that there was a threshold prior authorization of three and a half (3.5) hours of day treatment. None of these physicians could explain the "medical necessity" foundation for the reduction in hours.[137] A reasonable conclusion can be drawn from such evidence that Mr. Hanley and Mr. Jeffus were motivated to reduce benefits in order to save money. This inference is buttressed by the testimony of Ms. Gassaway that cost savings was the primary reason for awarding AFMC the peer review contract. It was also the underlying reason that AFMC was thereafter able to maintain the contract relationship.[138] Furthermore, Dr.

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[135] Plaintiffs' original Response to Motion for Summary Judgment, Ex. I.

[136] Plaintiffs' original Response to Motion for Summary Judgment, Ex. J.

[137] Plaintiffs' original Response to Motion for Summary Judgment, Ex. G p. 39, Ex. H, Plaintiffs' original Response, Ex. K p. 26.

[138] Plaintiffs' Supplemental Response to Motion, Ex. B pp. 33-35.

Whitaker's testimony confirmed that Marilyn Strickland, with ADHS, gave direct orders to AFMC administrators on how to limit nursing services in the day treatment centers. Dr. Whitaker stated that nursing services were primarily used for catheterized children and children in need of respiratory therapies. According to Dr. Whitaker, when it was discovered that such services could not be capped, Ms. Strickland instructed the nurses to send all requests for more than one unit per day for physician review before further approval. Dr. Whitaker identified the code numbers for nursing services as 99211 and 99212 – numbers which, under the new medicare guidelines, were limited to five (5) and ten (10) minutes per unit.[139] According to Dr. Whitaker, his approval of more than one (1) unit of nursing services per day for a catheterized child was overridden at the directive of "Medicaid."[140] Finally, Dr. Whitaker's "canned denials" present substantive evidence of an intent to deny the scope and duration of EPSDT services without a thorough evaluation of individual medical needs.[141]

Mr. Knickrehm, is director of the ADHS and has held that position since January, 1999. Mr. Ray Hanley was director of the Division of Medical Services of ADHS from 1994 through January 6, 2003. Roy Jeffus is the current director of Division of Medical Services of the Department of Human Services beginning on January 6, 2003. Before becoming director of the Division of Medical Services, Mr. Jeffus was its senior assistant director.

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[139] Plaintiffs' Supplemental Response to Motion, Ex. E pp. 58-59.

[140] Plaintiffs' Supplemental Response to Motion, Ex. E. pp 75-77.

[141] Plaintiffs' Supplemental Response to Motion Exhibit D.

Consequently, the evidence demonstrates that Mr. Hanley and Mr. Jeffus have been deeply involved in the administration of the state medical services program for many years. Mr. Hanley states that he was responsible for implementing the prior authorization process to curtail payment of unnecessary medical services.[142] It is the prior authorization process that is the focus of the controversial testimony of Ms. Gassaway and Dr. Whitaker. Mr. Jeffus states that the AFMC was awarded the state contract as a result of a bidding process and a review AFMC's proposals.[143] The contract entered into between the ADHS and the AFMC gave the Director of Medical Services oversight power as well as disciplinary power.[144] The testimony of Ms. Gassaway raises a reasonable inference that the bidding process and proposals included an evaluation of AFMC's willingness to make cost reduction its primary goal. Moreover, according to Ms. Gassaway, the only periodic information gathered by ADHC from AFMC related to cost savings, and not meeting the medical needs of eligible children.

Plaintiffs' presented evidence that Mr. Hanley and Mr. Jeffus – as key administrators of the division of medical services – either actually or constructively knew that the prior authorization process was being manipulated in a fashion that did not comport with the dictates of the Medicaid Act; and that abuses within the AFMC were condoned and overlooked.[145] In other words, the inference can be drawn that these two defendants acted affirmatively

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[142] Defendants' Motion for Summary Judgement Ex. 4.

[143] Defendants' Motion for Summary Judgement Ex. 3.

[144] Plaintiff's Response to Summary Judgement Ex. 24 pp. 24-26.

[145] *Pembaur,* 475 U.S. 483-84.

to reduce EPSDT services based on cost savings alone, without regard to medical need. There is evidence that the attorney for the individual capacity defendants was aware of the canned denials created and implemented by AFMC. It is a fair assumption that attorneys would, in turn, make their clients aware of material facts. There is evidence that administrators with Utilization – namely Ms. Wilson and Ms. Strickland – were instrumental in formulating AFMS undisclosed prior authorization guidelines. It is also a reasonable assumption that these two women were acting with the knowledge and support of their direct supervisors – Mr. Hanley and Mr. Jeffus.

In sum, Plaintiffs have presented evidence reasonably indicating that the individual Defendants knew that reducing the scope and duration of EPSDT services would adversely affect equal access to quality medical services for eligible children. There is sufficient evidence that equal access to these services was a clearly established right at the time Defendants implemented the policies in question here. Finally, Plaintiffs have come forward with enough evidence to create an inference that Mr. Hanley and Mr. Jeffus made affirmative choices that resulted in injury to Plaintiffs. However, Plaintiffs have failed to make a sufficient showing that Mr. Knickrehm, was in a position to know or take part in the conduct of Ms. Strickland and Ms. Wilson – or was aware of the alleged misconduct of individuals associated with AFMC. Consequently, Mr. Knickrehm is not liable for the actions of his subordinates in reducing medical care at the day treatment clinics.

CONCLUSION

In view of the above, Defendants' Motion for Summary Judgement and Supplemental Motion for Summary

Judgment is DENIED. I find, as a matter of law, Plaintiffs have standing to bring this action. Genuine disputes of material fact exist with respect to the motive for Defendants' implementation of the prior authorization process; with respect to the legitimacy of Defendants' medical necessity determinations; and with respect to the legitimacy of the manner in which the prior authorization process is applied. There are facts in dispute raising inferences pertinent to the violation of Plaintiffs' procedural and substantive due process rights; and that Ray Hanley and Roy Jeffus are not entitled to qualified immunity. There is not sufficient evidence to support liability against Kurt Knickrehm for civil damages.

It is therefore CONSIDERED, ORDERED AND ADJUDGED that Defendants' Motion for Summary Judgement and Supplemental Motion for Summary Judgment are DENIED (Doc. Nos. 162 and 253). The individually named Defendants – Ray Hanley and Roy Jeffus – are not entitled to qualified immunity. Kurt Knickrehm is entitled to immunity from civil damages. Finally, the Motion to Rule on the Issue of Qualified Immunity is DENIED as MOOT.

IT IS SO ORDERED THIS 7th day of February, 2005

/s/ Wm. R. Wilson, Jr.
UNITED STATES
DISTRICT JUDGE
WM. R. WILSON, JR.

THIS DOCUMENT ENTERED ON DOCKET SHEET IN COMPLIANCE WITH RULE 58 AND/OR 79(a) FRCP ON 2/7/05 BY [Illegible]

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UNITED STATES DISTRICT COURT
Eastern District of Arkansas
U.S. Court House
600 West Capitol, Suite 402
Little Rock, Arkansas 72201-3325

February 7, 2005

* * MAILING CERTIFICATE OF CLERK * *

Re: 4:01-cv-00830.

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Date: ___2/7/05___ BY: ___Doris Collins___

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 05-1115/05-1116

Pediatric Specialty Care, Inc., et al.,	*	
Appellees,	*	Order Denying Petition for Rehearing and for Rehearing En Banc
v.	*	
Arkansas Foundation for Medical Care,	*	
Appellants.	*	

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

(5128-010199)

June 22, 2006

Order Entered at the Direction of the Court:

Clerk, U.S. Court of Appeals, Eighth Circuit

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION
FILE NUMBER 4:01CV00830 WRW

PEDIATRIC SPECIALTY CARE, INC., et al.,	)	
Plaintiffs	)	
v.	)	Notice of Appeal
ARKANSAS DEPARTMENT OF HUMAN SERVICES, et al.	)	
Defendants	)	

(Filed Mar. 08, 2005)

Notice is hereby given that the Arkansas Department of Human Services; Ray Hanley, in his individual capacity; and Roy Jeffus in his individual capacity, hereby appeal to the United States Court of Appeals for the Eighth Circuit from the Order denying qualified immunity to Ray Hanley and Roy Jeffus in their individual capacities, and continuing jurisdiction over the Arkansas Department of Human Services, entered in this case on February 7, 2005.

/s/ Breck G. Hopkins
Breck G. Hopkins
Arkansas Bar Number 77065
Attorney for the Arkansas Department of Human Services
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CERTIFICATE OF SERVICE

I, Breck Hopkins, do hereby certify that a copy of the above and foregoing was served upon Philip E. Kaplan, Attorney at Law, 415 Main Street, Little Rock, AR 72201; Martin W. Bowen, Attorney at Law, 100 Morgan Keegan Drive, Suite 100, Little Rock, Arkansas 72202; Mike Rainwater, Attorney at Law, 6315 Ranch Drive, Little Rock, Arkansas 72223; Richard Pence, Assistant United States Attorney, P.O. Box 1229, Little Rock, AR 72203, by placing a true and correct copy to each in the U. S. mail, with sufficient postage prepaid, this 8 day of March, 2005.

/s/ [Illegible]
Breck Hopkins

(4)

No. 06-415

Supreme Court, U.S.
FILED
JAN 25 2007
OFFICE OF THE CLERK

In The Supreme Court of the United States

JOHN SELIG in his official capacity as Director of the ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES; RAY HANLEY in his individual capacity as former Director of the DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES; and ROY JEFFUS, in his individual capacity and his official capacity as Director of the DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioners,

vs.

PEDIATRIC SPECIALTY CARE, INC.; CHILD AND YOUTH PEDIATRIC DAY CLINICS, INC.; FAMILY COUNSELING AND DIAGNOSTIC CLINIC; TOMORROW'S CHILD LEARNING CENTER LLC; D AND D FAMILY ENTERPRISES, INC.; JAMES SWINDLE and STACEY SWINDLE as parents and next best friends of JACOB and NOAH SWINDLE, minors; SUSANN CRESPINO, as parent and next best friend of MICHAEL CRESPINO,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

SUPPLEMENTAL AUTHORITY IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI AND IN REPLY TO RESPONDENTS' BRIEF IN OPPOSITION

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I. THIS COURT SHOULD CONSIDER *OKLAHOMA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS V. FOGARTY* IN SUPPORT OF PETITIONERS' WRIT OF CERTIORARI

The Arkansas Department of Health and Human Services, Ray Hanley in his individual capacity, and Roy Jeffus in his individual capacity and his official capacity as Director of the Division of Medical Services of the Department of Health and Human Services (state defendants), submit for this Court's consideration the decision of the Tenth Circuit Court of Appeals in *Oklahoma Chapter of the American Academy of Pediatrics v. Fogarty*, __F.3d__, 2007 WL 10760 (10th Cir. Jan. 3, 2007) pursuant to Sup. Ct. R. 15(8). There are three reasons for reviewing the *Fogarty* decision in the context of the state defendants' pending Petition for Writ of Certiorari.

First, the Tenth Circuit ruled that 42 U.S.C. § 1396a(a)(30)(A)[1] does not create privately enforceable rights under 42 U.S.C. § 1983. The Tenth Circuit thereby joins the First, Sixth and Ninth Circuit Courts of Appeal on this issue. The Eighth Circuit continues to stand alone.

Second, the *Fogarty* opinion concerns Medicaid services to persons under age 21, commonly referred to as Early and Periodic Diagnosis, Screening, and Treatment ("EPSDT") services. EPSDT services are referenced at 42

[1] This section provides in pertinent part that a State plan for medical assistance must "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans . . .) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care."

U.S.C. § 1396d(a)(4)(b) and defined at 42 U.S.C. § 1396d(r). It is critical that *Fogarty* involved EPSDT services because the respondents argue that (1) 42 U.S.C. § 1396a(a)(30)(A) is not controlling, and (2) the EPSDT definitions of Section 1396d create a private right of action under Section 1983. Faced with similar arguments, *Fogarty* relied on Section 1396a(a)(30)(A) to analyze a private cause of action based upon EPSDT services instead of the definitions of EPSDT services found in Sections 1396d(a)(4)(b) and (r).

As *Fogarty* points out, EPSDT is defined as: (1) Periodic screenings (not at issue in this case); and (2) "Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Subsection 1396d(a) defines the medical assistance that states are authorized to reimburse under state Medicaid plans. As a condition of Medicaid coverage, Child Health Management Services ("CHMS") must fit one of these definitions. The only definition of medical assistance applicable to CHMS is in subsection (a)(13): "[O]ther diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services . . . recommended by a physician . . . within the scope of their practice for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level[.]"

CHMS fits this definition because CHMS services are recommended by physicians for the maximum reduction of physical or mental disability. (A service delivery model that proposed to put a band-aid on a broken arm would not

qualify under the definition of medical assistance set out in subsection (a)(13) because the treatment would not be for the maximum reduction of the disability stemming from the broken arm.) CHMS therefore meets the threshold test of qualifying as medical assistance, and in turn fits within the EPSDT definition. Accordingly, Arkansas Medicaid reimburses medically necessary CHMS care furnished to Medicaid eligible persons under age 21.

The sole purpose of medical assistance definitions such as Section 1396d(a)(13) is to determine whether state Medicaid programs are authorized to cover particular care. Respondents wrongly assert that the definition in subsection (a)(13) is a floor for the quantity of services to be provided, when this definition actually is a limitation on the type of care defined as medical assistance. *See* Respondents' Brief in Opposition to Writ of Certiorari (respondents assert a "federal right to EPSDT services in an amount [six hours] that will result in the maximum reduction of physical and mental disability").

The *Fogarty* Court understandably did not identify any such right flowing from the definitions of medical assistance and EPSDT in Section 1396d. As used in subsection (a)(13), "maximum" modifies the word "reduction" and sets the goal of the treatment plan. It does not refer to the quantity of services necessary to carry out a particular CHMS treatment plan for a particular child, nor does it refer to the speed with which the treatment goal must be reached.

The quantity of CHMS medical assistance that is medically necessary for a particular eligible child is a medical judgment. This brings the real issue into focus: how much CHMS treatment is medically necessary for

each eligible child? The respondents' disagreement with the medical necessity judgments of board-certified pediatricians is a utilization question that must be resolved under 42 U.S.C. § 1396a(a)(30)(A) using the dispute resolution procedures set out in 42 U.S.C. § 1396a(3). The *Fogarty* opinion recognizes that this is the issue and holds that Section 1396a(a)(30)(A) creates no privately enforceable rights, resolving the private enforcement question in favor of the state defendants.

Third, and specific only to the history of this case, the Tenth Circuit ruled that the District Court erred when it ordered the State Medicaid Agency to conduct a study of rates, costs, and services to determine if its rates were adequate. By contrast the Eighth Circuit ruled that 42 U.S.C. § 1396a(a)(30)(A) requires such studies not only in connection with rates, but also as a condition precedent to Medicaid state plan amendments having nothing to do with payment rates. *Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Services*, 364 F.3d 925, 929-30 (8th Cir. 2004).

II. CONCLUSION

The *Fogarty* decision is important precedent because: (1) it reinforces the other circuit courts of appeals decisions that conclude there is no private right of action under 42 U.S.C. § 1396a(a)(30)(A); (2) it considers and implicitly rejects arguments that the definitions of medical assistance, which include EPSDT, at 42 U.S.C. § 1396d create private rights of action; and (3) it holds it was error for the district court to order a State Medicaid Agency to conduct

a study of rates, costs, and services to determine if its rates were adequate.

Respectfully submitted,

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No. 06-415

FILED

JUN 11 2007

OFFICE OF THE CLERK
SUPREME COURT

In The Supreme Court of the United States

JOHN SELIG, in his official capacity as Director of the ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES; RAY HANLEY in his individual capacity as former Director of the DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES; and ROY JEFFUS, in his individual capacity and his official capacity as Director of the DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioners,

vs.

PEDIATRIC SPECIALTY CARE, INC.; CHILD AND YOUTH PEDIATRIC DAY CLINICS, INC.; FAMILY COUNSELING AND DIAGNOSTIC CLINIC; TOMORROW'S CHILD LEARNING CENTER LLC; D AND D FAMILY ENTERPRISES, INC.; JAMES SWINDLE and STACEY SWINDLE as parents and next best friends of JACOB and NOAH SWINDLE, minors; SUSANN CRESPINO, as parent and next best friend of MICHAEL CRESPINO,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITIONERS' RESPONSE TO RESPONDENTS' SUGGESTION OF MOOTNESS

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PETITIONERS' RESPONSE TO RESPONDENTS' SUGGESTION OF MOOTNESS

Pursuant to Rule 21.2(b) of the Rules of this Court, Petitioners respectfully request that the Court vacate the judgment of the United States Court of Appeals for the Eighth Circuit and remand the case to that court with directions to dismiss with prejudice Respondents' individual capacity and money damages claims against Petitioners Ray Hanley and Roy Jeffus.

Respondents filed a Suggestion of Mootness, in which they state that they no longer wish to pursue their individual capacity and money damages claims against Messrs. Hanley and Jeffus. Because the Petition for Writ of Certiorari arises from the Eighth Circuit's denial of qualified immunity to these individual defendants for those claims for relief, Respondents' voluntary withdrawal of these claims renders the petition moot. Respondents' unilateral action has denied Petitioners their opportunity for review of the judgment, which conflicts with decisions of this Court and of other courts of appeals, and which has significant adverse implications for the States' administration of the Medicaid program. *See* PETITION FOR WRIT OF CERTIORARI, pp. 8-30; BRIEF OF STATES AND STATE AGENCIES AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS, pp. 8-19. Accordingly, this Court should vacate the court of appeals judgment and direct the court to dismiss with prejudice Respondents' individual and money damage claims against Messrs. Hanley and Jeffus. Vacatur with directions to dismiss with prejudice is the established practice when a civil case becomes moot pending the court's decision on the merits. *U.S. Bancorp Mortg. Co. v. Bonner Mall P'ship*, 513 U.S. 18, 22 (1994).

The Eighth Circuit denied Messrs. Hanley and Jeffus qualified immunity from claims brought by Respondents

pursuant to 42 U.S.C. § 1983. Review was based upon the collateral order doctrine. *Johnson v. Jones*, 515 U.S. 304, 311 (1995) (collateral order doctrine allows a court to review a denial of summary judgment when the order is based upon a denial of qualified immunity). Petitioners seek review in this Court of the following two issues, which arise from the decision denying qualified immunity:

> 1. PRIVATE ENFORCEMENT: Does the statute defining the services that state Medicaid programs are authorized to cover create private rights that are enforceable under 42 U.S.C. § 1983? Does the statute that obligates states to safeguard against unnecessary Medicaid utilization create private rights that are enforceable under 42 U.S.C. § 1983?
>
> 2. QUALIFIED IMMUNITY: Are state Medicaid directors subject to personal monetary liability under § 1983 for: (a) Medical necessity decisions made by independent board-certified physicians engaged (but not employed) by a federally designated independent contractor of the state Medicaid program; or (b) Unauthorized conduct of a nurse employed by the federally designated independent contractor?

PETITION FOR WRIT OF CERTIORARI, page (i).

After briefing on the Petition for Writ of Certiorari was complete, during which the Respondents filed a brief in opposition, *Amici Curiae* of States and State Agencies filed a brief in support, and Petitioners filed a reply and supplemental brief, this Court invited the Office of the Solicitor General to file a brief expressing the views of the United States. Petitioners and Respondents subsequently met with representatives of the Solicitor General to discuss

the case. By letter dated May 18, 2007, Respondents notified Petitioners and the Solicitor General that they had decided to dismiss with prejudice their claims for money damages filed against Messrs. Jeffus and Hanley in their individual capacities. On June 1, 2007, Respondents filed a Suggestion of Mootness, in which they represent that they wish to permanently withdraw and dismiss with prejudice their individual capacity and money damages claims against Messrs. Hanley and Jeffus.

In light of these circumstances, Petitioners concur that if these claims of Respondents are dismissed with prejudice, the Petition for Writ of Certiorari is moot. However, because the mootness arises from the unilateral action of Respondents, which prevents Petitioners from obtaining review of an unfavorable judgment, Petitioners request that the Court vacate the judgment of the court of appeals and order that the individual capacity and money damages claims against Messrs. Hanley and Jeffus be dismissed with prejudice. That disposition will remove the precedential force of the Eighth Circuit's decision and will clear the path for future relitigation of the issues between the parties. Vacatur is appropriate because the "unilateral action of the party who prevailed in the lower court" has denied Petitioners the opportunity to obtain review of the court of appeals' judgment. *Arizonans for Official English v. Arizona*, 520 U.S. 43, 72 (1997) (quoting *U.S. Bancorp Mortg. Co.*, 513 U.S. at 23).

STATEMENT

1. This litigation dates back to December 6, 2001, but this case arises from the plaintiffs' Fifth Amended Complaint. In that complaint, the plaintiffs sought damages and

injunctive relief under 42 U.S.C. § 1396a(a)(30)(A) and 42 U.S.C. § 1396d(a)(13). They sued the Director of the Arkansas Department of Health and Human Services ("DHHS"), John Selig, in his official capacity, Ray Hanley, in his individual capacity as former Director of the Division of Medical Services of DHHS, and Roy Jeffus, in his individual capacity and his official capacity as Director of the Division of Medical Services of DHHS. Respondents alleged that DHHS's use of a prior authorization process for day treatment, a form of day care in which classroom teachers reinforce therapies such as speech therapy, occupational therapy, and physical therapy, resulted in a decrease in the number of hours approved for these services, and that this resulted in damages to the plaintiffs. They sought money damages, as well as declaratory and injunctive relief dictating a minimum amount of day treatment (six hours) that each reviewing physician must in the future determine to be medically necessary.

2. Petitioners moved for summary judgment, arguing that the Respondents had no privately enforceable rights under 42 U.S.C. § 1396a(a)(30)(A) and 42 U.S.C. § 1396d(a)(13) and that Ray Hanley and Roy Jeffus were entitled to qualified immunity. The district court denied Petitioners' motion for summary judgment, holding that (1) both federal statutes created rights enforceable by both providers and recipients, (2) Messrs. Hanley and Jeffus were not entitled to qualified immunity and thus could be held personally liable for money damages claimed by Respondents, and (3) DHHS was not entitled to Eleventh Amendment immunity (this was not specifically addressed in the order, but the summary judgment motion was denied in its entirety).

3. Petitioners appealed only the order denying qualified immunity to Messrs. Hanley and Jeffus and denying Eleventh Amendment immunity to DHHS to the Eighth Circuit Court of Appeals on March 8, 2005 pursuant to 28 U.S.C. § 1291 and the collateral order doctrine. Petitioners argued that (1) 42 U.S.C. § 1396a(a)(30)(A)[1] does not give providers or recipients of Medicaid services enforceable rights under § 1983, (2) 42 U.S.C. § 1396d(a)(13)[2] does not give providers enforceable rights under § 1983, (3) the individual petitioners did not violate a federal statutory right by establishing a system of prior authorization review implemented by a federally-certified peer review organization, (4) a reasonable official would not know his conduct was unlawful where qualified physician reviewers determined that no more than 3.5 – 4 hours of core child health management services was medically necessary, and (5) DHHS, an agency of the State of Arkansas, was

---

[1] 42 U.S.C. § 1396a(a)(30)(A) requires state plans to: "[P]rovide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1902(i)(4) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

[2] 42 U.S.C. § 1396d(a)(13) provides: (a) For purposes of this title the term "medical assistance" means payment of part or all of the cost of the following care and services . . . (13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."

entitled to immunity from suit in federal court under the Eleventh Amendment.

4. With respect to whether §§ 1396a(a)(30)(A) and 1396d(a)(13) provide enforceable private rights of action, Petitioners argued that *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002) was controlling. Petitioners contended that the two federal statutes at issue do not contain the unambiguously conferred rights required by *Gonzaga*, and fail to identify a discrete class to whom the rights belong. On the issue of Messrs. Hanley and Jeffus' qualified immunity, Petitioners argued the implementation of a federally authorized peer review process violated no statutory rights. Further, even assuming that it did, no reasonable official would know his conduct was unlawful in light of the law allowing for federally-certified peer review and the conclusions of the qualified physician reviewers.

5. The Eighth Circuit Court of Appeals issued its decision on Petitioners' appeal on April 17, 2006. It upheld the district court's order denying Messrs. Hanley and Jeffus qualified immunity and allowing causes of action based upon §§ 1396a(a)(30)(A) and 1396d(a)(13). Rehearing and Rehearing En Banc were denied on June 22, 2006.

6. Petitioners timely filed their Petition for Writ of Certiorari on September 20, 2006. Briefing concluded on January 25, 2007, and this Court invited the Solicitor General to file a brief expressing the views of the United States on February 20, 2007.

7. The Petition for Writ of Certiorari explained that an exercise of this Court's certiorari jurisdiction was warranted because the Eighth Circuit's decision that 42 U.S.C. § 1396a(a)(30)(A) creates privately enforceable rights conflicts with decisions of other courts of appeals. In

addition, conflicts among the circuits exist not only with respect to 42 U.S.C. § 1396a(a)(30)(A), but also as to the scope of the rights created by 42 U.S.C. § 1396d(r). Since this Court's decision in *Gonzaga,* the following courts have held that § 1396a(a)(30)(A) creates no privately enforceable rights. *Westside Mothers v. Olszewski*, 454 F.3d 532, 542 (6th Cir. 2006) (holding no private enforcement); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 59 (1st Cir. 2004) (holding no provider enforcement); *Sanchez v. Johnson*, 426 F.3d 1051, 1062 (9th Cir. 2005) (holding no individual rights created); *Oklahoma Chapter of the American Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208 (10th Cir. 2007) (holding no private enforceable rights). Only the Eighth Circuit has refused to follow *Gonzaga*, which held that Congress confers enforceable rights only when it uses "rights-creating" language. *Gonzaga*, 536 U.S. at 287.

8. With respect to the scope of the rights contained in 42 U.S.C. § 1396d(r) (the definition of Early and Periodic Diagnosis, Screening, and Treatment ("EPSDT") services, which are Medicaid services provided to persons under age 21), the Ninth Circuit Court of Appeals defines the rights privately enforceable under EPSDT as the right to compel state Medicaid plans to pay for all of the component services listed in § 1396d. *Katie A. v. Los Angeles Co.*, 481 F.3d 1150 (2007) (also holding there is no enforceable right to services in particular bundles or in accordance with particular principles); *see also Fogarty*, 472 F.3d at 1215 (holding that a state only is required to cover EPSDT services and not to provide them). These decisions conflict with the Eighth Circuit's decision, which is that there is an enforceable right to a particular services bundle, and

also an enforceable right to define that bundle in accordance with particular principles (six hours of care). Petitioners also contend that the case is worthy of certiorari because of its potential to impede a state's ability to utilize peer review organizations to review medical necessity decisions.

9. The case also is worthy of certiorari because the qualified immunity decision cannot be reconciled with precedent that only removes qualified immunity for violations of clearly established rights, and refuses to remove qualified immunity based upon *respondeat superior* or vicarious liability. *Harlow v. Fitzgerald*, 457 U.S. 800 (1982); *Mitchell v. Forsyth*, 472 U.S. 511 (1985); *Monell v. Dep't of Social Servs. of the City of New York*, 436 U.S. 658 (1978). The Eighth Circuit's holding on qualified immunity would impose liability upon government officials based upon the actions of a governmental agency contractor's employees, which directly conflicts with the rule against liability based upon *respondeat superior* or vicarious liability. In addition, the Eighth Circuit found that the mere implementation of a prior authorization process that reduced the scope and duration of services could remove qualified immunity, despite a federal statute allowing and encouraging states to implement utilization controls.

10. Fourteen states and state agencies filed a brief as *Amici Curiae* supporting the Petition for Writ of Certiorari. That brief explained that if the decision is allowed to stand, it will "materially impede States' efforts to deal with the growing cost of the Medicaid program, threatening state officials with personal liability for implementing policies designed to control costs." *Amici Curiae* Brief, p. 1.

Amici Curiae agree that there is no federal right, much less a clearly established one, to Medicaid services free of prior authorization. *Id.* at p. 12.

11. On May 18, 2007, Respondents sent a letter to Petitioners and to the Solicitor General stating that they planned on dismissing their claims against Messrs. Hanley and Jeffus. On June 1, 2007, Respondents filed a Suggestion of Mootness with this Court, in which they represent that they no longer want to pursue their personal capacity and money damages claims against Ray Hanley and Roy Jeffus and will dismiss these claims with prejudice. Given that the petition is based upon a denial of qualified immunity, the representations moot the petition because the qualified immunity issue is no longer justiciable under Article III of the U.S. Constitution. However, because the mootness was caused by the unilateral action of Respondents, vacatur of the decision below with directions to dismiss these claims with prejudice is appropriate because Respondents' actions have denied Petitioners their right to review in this Court of an unfavorable decision.

ARGUMENT

The Respondents' representations that they no longer wish to pursue their individual capacity and money damages claims against Ray Hanley and Roy Jeffus and that they will dismiss these claims with prejudice render this case moot. That unilateral action by Respondents has deprived Petitioners of the opportunity to obtain this Court's review of the Eighth Circuit's decision, and its adverse implications for the administration of State

Medicaid programs. *See* PETITION FOR WRIT OF CERTIORARI, pp. 28-30; *Amici Curiae* Brief, pp. 8-12.

If a case becomes moot pending review, "this Court may consider its merits, but may make such disposition of the whole case as justice may require." *U.S. Bancorp Mortg. Co.*, 513 U.S. at 21. "The established practice of the Court in dealing with a civil case from a court in the federal system which has become moot . . . pending [the Court's] decision on the merits is to vacate the judgment below and remand with a direction to dismiss." *Id.* at 22 (quoting *United States v. Munsingwear, Inc.*, 341 U.S. 36, 39 (1950)). In these circumstances, vacatur "clears the path for future litigation of the issues between the parties and eliminates a judgment, review of which was prevented through happenstance." *Munsingwear*, 340 U.S. at 40; *see also Deakins v. Monaghan*, 484 U.S. 193, 200 (1988) (stating that when a claim is rendered moot while awaiting review by the Supreme Court, "the judgment below should be vacated with directions to the District Court to dismiss the relevant portion of the complaint.").

Respondents' representation concerning their abandonment of their claims for damages relief against Messrs. Hanley and Jeffus provide a proper basis for vacatur. In *Deakins*, the respondents represented through counsel that they did not want to pursue claims for equitable relief in the federal court. They stated that they wanted to seek such relief in another forum. *Deakins*, 484 U.S. at 198. The Court stated that for the purpose of Article III's case or controversy requirement, it is not enough that a "controversy existed at the time the complaint was filed, and continued to exist when review was obtained in the Court of Appeals." *Id.* at 199 (quoting *Sosna v. Iowa*, 419 U.S. 393, 402 (1975)). The Court held:

> In the case now before us, respondents state that they no longer seek any equitable relief in federal court. Because there no longer is a live controversy between the parties over whether a federal court can hear respondents' equitable claims, the first question on which certiorari was granted is moot.

Deakins, 484 U.S. at 199.

Indeed, this Court has held in a series of decisions that vacatur is appropriate when the party who prevailed in the lower court renders the case moot by receding from its position. For example, in *Frank v. Minnesota Newspaper Ass'n*, 490 U.S. 225 (1989) (per curiam), in light of a concession by the appellant government officials, the plaintiff-appellee in this Court "state[d] its willingness to forgo any further claim to the . . . relief sought in its complaint." *Id.* at 227. Concluding that the case was moot, the Court vacated the judgment below and remanded with directions to dismiss. *Ibid.* (citing *Munsingwear*). See also *Webster v. Reproductive Health Services*, 492 U.S. 490, 512-513 (1989) (*Munsingwear* treatment in response to withdrawal by plaintiffs/appellees of request for relief in light of appellant's legal position); *Gray v. Board of Trustees of the Univ. of Tennessee*, 342 U.S. 517, 518 (1952) (per curiam) (similar treatment where action of appellee mooted controversy); *Commercial Cable Co. v. Burleson*, 250 U.S. 360, 362 (1919) (same); *Board of Governors of Federal Reserve Sys. v. Security Bancorp*, 454 U.S. 1118 (1981) (*Munsingwear* treatment where respondent's actions mooted application for permission to acquire bank); *DeFunis v. Odegaard*, 416 U.S. 312 (1974) (per curiam) (vacating judgment of state supreme court after case was rendered moot by action of respondent).

Vacatur is likewise appropriate in this case because the unilateral action of the party who prevailed in the

lower court has denied Petitioners the opportunity to seek review of the Eighth Circuit's judgment and thus to prevent the continuing adverse effects on the administration of the Medicaid program that have arisen from that Court's holding that Medicaid officials can be liable for millions of dollars in their individual capacities. Absent vacatur, Petitioners would otherwise object to a dismissal of the Petition for Writ of Certiorari without an accompanying order vacating the court of appeals decision and directing a dismissal with prejudice of the money damages and individual capacity claims against Messrs. Hanley and Jeffus. Having been deprived of the opportunity for this Court's review, Petitioners and the *Amici* states and state agencies should not be forced to endure that decision's continuing adverse implications. Petitioners should not be saddled with an unfavorable decision when they have been denied the opportunity to obtain review in this Court.

For the foregoing reasons, the Court should vacate the judgment of the United States Court of Appeals for the Eighth Circuit and remand the case to that court with directions to order the vacation of the judgment of the district court and the dismissal of the Respondents' money damages and individual capacity claims against Messrs. Hanley and Jeffus with prejudice.

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In The
Supreme Court of the United States

JOHN SELIG in his official capacity as Director of the ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES; RAY HANLEY in his individual capacity as former Director of the DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES; and ROY JEFFUS, in his individual capacity and his official capacity as Director of the DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioners,

vs.

PEDIATRIC SPECIALTY CARE, INC.; CHILD AND YOUTH PEDIATRIC DAY CLINICS, INC.; FAMILY COUNSELING AND DIAGNOSTIC CLINIC; TOMORROW'S CHILD LEARNING CENTER LLC; D AND D FAMILY ENTERPRISES, INC.; JAMES SWINDLE and STACEY SWINDLE as parents and next best friends of JACOB and NOAH SWINDLE, minors; SUSANN CRESPINO, as parent and next best friend of MICHAEL CRESPINO,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

REPLY TO BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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REPLY TO BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

I. Ray Hanley and Roy Jeffus are Entitled to Qualified Immunity.

In their Brief in Opposition the respondents say nothing about the serious impact that the Eighth Circuit decision will have on Medicaid programs. Similarly, the respondents offered no response to the points made in the amicus brief filed by numerous states. Indeed, they ignored the brief altogether.

The impact of the Eighth Circuit decision on states will be three-fold. First, states attempting to hire Medicaid administrators will doubtless find that desirable individuals will not apply because they do not want to assume the risk of personal liability that the Eighth Circuit decision imposes. Second, even though Medicaid programs must have effective methods and procedures to prevent unnecessary care, and even though federal law provides for administrative review of each adverse medical necessity decision, Medicaid providers can tie up Medicaid administrators in federal court litigating their states' utilization control processes. Third, and most important to the needy individuals that Medicaid serves, by threatening Medicaid administrators with personal liability for implementing federally authorized utilization control procedures the Eighth Circuit decision substantially decreases the likelihood that Medicaid programs will effectively eliminate payments for unnecessary care. As Medicaid budgets are squeezed, coverage reductions affecting the truly needy are often the result.

The respondents have not come close to making a case that the only conduct attributed to Ray Hanley – establishing prior authorization medical necessity reviews in the Child Health Management Services ("CHMS") program – violated any clearly established right. In fact, the respondents barely mention the "clearly established right" test, much less satisfy it.

Though the respondents argue that the Supreme Court should not consider qualified immunity because the issue is fact-specific, that is not the case. The petitioners do not ask this Court to review any factual issue. Rather, petitioners raise a legal question of great importance to states. The Eighth Circuit held that state officials are not entitled to qualified immunity based on their creation of a prior authorization program, and that holding raises serious concerns. The factual issues the respondents cite are largely beside the point. In any event, their factual arguments are misguided and do not suggest that Ray Hanley and Roy Jeffus violated any clearly established right.

In this case the alleged right is publicly funded medical care that a board-certified physician has determined is medically unnecessary, or, alternatively, favorable medical necessity determinations. It cannot be argued that such rights are clearly established because they do not exist at all.

The fact question in this case – whether AFMC's board-certified physician reviewers' medical necessity denials were correct – is not raised or argued in the Petition for Writ of Certiorari. Regardless of the ultimate resolution of that question, neither Ray Hanley nor Roy Jeffus should be subjected to personal money damages as a consequence of medical necessity decisions made by

AFMC's physicians, particularly considering that federal law both authorizes and encourages states to engage federally certified Utilization and Quality Control Peer Review Organizations such as AFMC. *See* 42 U.S.C. § 1396a(d).

In their attempts to generate fact-specific issues the respondents rely heavily on information that AFMC denied as unnecessary some CHMS services that were routinely provided before there was any systematic medical necessity oversight of CHMS. That, however, is no evidence of wrongdoing. To the contrary, it establishes that the CHMS medical necessity reviews accomplish Congress' goals in enacting peer review and mandating Medicaid utilization controls to prevent unnecessary care. *See* 42 U.S.C. §§ 1320-c and 1396a(a)(30)(A).

The petitioners also rely heavily on a notice published in 1999 in the ARKANSAS DEMOCRAT-GAZETTE newspaper. A.C.A. § 25-15-204 requires such notice as a condition of adopting rules, in this instance, the rule requiring medical necessity reviews in the CHMS program. State law also requires that the notice contain a financial impact statement. A.C.A. § 25-15-204(d)(3)(A). The state, therefore, was obligated to publish an estimate of savings that could result from medical necessity reviews. The respondents cite that statutorily required estimate as evidence of wrongdoing, even though there is no evidence that Hanley or Jeffus made the estimate, or that the estimated savings actually materialized.

To summarize, the petitioners argue that qualified immunity should be denied because medical necessity reviews work as Congress intended, and because public

officials undertook certain tasks that are ministerial under state law.

The respondents' arguments obscure the real issue: Ray Hanley and Roy Jeffus acted in accordance with federal and state laws and as a result are being forced to defend against staggering personal damages claims for decisions they did not make. Put another way, the Eighth Circuit decision forces Medicaid administrators to second guess board-certified physicians correctly (that is, consistently with the trial court) or face personal bankruptcy. No fact-specific inquiry is necessary to overturn such a radical departure from well-settled qualified immunity law followed by this Court and every other Circuit Court of Appeals. And, if the Eighth Circuit's decision is not overturned, it is difficult to overstate the ultimate impact upon publicly funded health care for the poor when top-notch administrators refuse Medicaid jobs and spiraling costs exhaust funds designated for the truly needy.

II. There is a Split Among the Circuits

Ray Hanley and Roy Jeffus did not influence or interfere with any of the medical necessity decisions made by board-certified physicians engaged by AFMC. The respondents sued because those board-certified physicians did not approve all the care that they wanted to furnish.[1]

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[1] The misconduct of AFMC's nurse Coats was not known to the respondents when they sued Hanley and Jeffus over the medical necessity denials. The respondents and the Eighth Circuit exploited the subsequent discovery of Nurse Coat's activities to cast a shadow upon Hanley and Jeffus even though neither had any connection to or contact with Nurse Coats, and had no notice of Nurse Coats' activities before the respondents disclosed those activities in pleadings filed in this case.

(Continued on following page)

Aside from qualified immunity, the Petition raises only one issue: Is there any well-established and enforceable federal right to favorable medical necessity decisions or to any care that is not medically necessary? As explained elsewhere, there is no such right, and certainly no unambiguously conferred individual federal right. Rather than address this point, the respondents assert enforceable rights under the Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") as defined in 42 U.S.C. § 1396d(r). But the petitioners do not dispute that Medicaid recipients under age twenty-one are entitled to medically necessary services under EPSDT or that CHMS are EPSDT services. The fact remains, however, that Medicaid may not pay for unnecessary care, regardless of the type of care or age of the beneficiary. 42 U.S.C. § 1396a(a)(30)(A). Because the question is the medical necessity of some CHMS care, not whether CHMS qualifies as an EPSDT service, the respondents' EPSDT arguments are a red-herring designed to mask the fact that there is a clear split among the circuits on the enforceability of 42 U.S.C. § 1396(a)(A)(30)(A).

All the complained-of medical necessity reviews were undertaken to comply with the Medicaid utilization control mandates in 42 U.S.C. § 1396a(a)(30)(A) and 1396d. Section (a)(30)(A) has two subjects: rate-setting and utilization control. The utilization control mandate forbids "unnecessary utilization of . . . care." Rather than address this issue the respondents again attempt to obscure the

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The real issue is not Nurse Coats' conduct before AFMC transferred her from CHMS reviews, but rather the underlying complaint that AFMC's board-certified physicians are not approving the volume of care that CHMS providers would like.

point by arguing that in determining medical necessity the state had to follow rate-setting provisions in Section a(a)(30)(A). Those provisions require states to assure that Medicaid "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." *Id.*

The provision forbidding payment for unnecessary services is functionally and conceptually distinct from the provision setting standards for payments that are made "for care and services under the plan." The latter refers, as a matter of simple English, to the amount of payment that the state makes for particular covered services, not to payments that are not made at all.

Respondents' attempts to intertwine standards for prohibiting payments (medical necessity) with the standards for making payments (the four rate-setting factors) lead to the inescapable conclusion that the respondents envision some guarantee of minimum service volume or particular provider revenues, concepts that are anathema to the Medicaid program, which provides only that the amount actually paid for each service must comply with the four factors.

As originally enacted in 1967, (a)(30)(A) required states to provide:

> Such methods and procedures relating to the . . . payment for [] care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care, and assure that

> payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care . . . .

Section 237, P.L. 90-248, 81 Stat. 821 (1967).

By tying "payments" to "reasonable charges" Congress clearly demonstrated that "payment" meant rates. That is further confirmed by the legislative history. Congress designed the rate setting provisions to assure that Medicaid did not set its prices too low to attract enough providers. H.R. Rep. No. 101-247 at 390, 1989 U.S. Cong. Adm. News 1906, 2116.

Respondents make no claim that Medicaid rates are so low that they can no longer afford to provide CHMS services. In fact, the reverse is true: the respondents want to provide more CHMS care at the existing Medicaid payment rates. Ignoring this irony, the respondents advance the illogical claim that medical necessity must be determined in consideration of the rate-setting factors of efficiency, economy, quality of care, and access. However, Medicaid makes no payment in any amount unless the care is medically necessary. When there is no payment, the payment factors of economy and efficiency are irrelevant. Similarly, if care is not medically necessary and thus not covered for that individual on that day, it is senseless to ask whether the individual has access to the non-covered care. Thus, the provisions cited by the respondents have no application to the medical necessity determinations at issue in this case.[2]

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[2] Other than the District Court and the Eighth Circuit, no court has applied the four rate-setting factors in 42 U.S.C. § 1396a(a)(30)(A)

(Continued on following page)

Having failed to identify any federally enforceable right applicable to the medical necessity transactions at issue in this case, the respondents simply changed the subject and pointed to rate-setting language. However, the Petition raises no Medicaid rate-setting issues, and the respondents' references to irrelevant issues should not dissuade the Court from granting the Petition.

The respondents do not deny that there is a split among the circuits as to the enforceability of 42 U.S.C. § 1396a(a)(30)(A). Rather than confront the split head-on, they mistakenly assert that they are enforcing 42 U.S.C. § 1396d(a)(13) which, as explained in the Petition, is a definition of Medicaid services. If the respondents were really enforcing the definition of services in § d(a)(13), the dispute would center on whether CHMS services fit that definition. But that is not in dispute: Arkansas Medicaid pays each and every claim for CHMS services for eligible recipients when AFMC's board-certified physicians determine that the services are medically necessary.

III. Conclusion

The petitioners therefore respectfully ask this Court to declare that there is no federally enforceable right in connection with medical necessity transactions under 42

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to anything other than rate setting. *See, e.g., Himes v. Shalala*, 999 F.2d 684 (2d Cir. 1993); *Sobky v. Smoley*, 855 F.Supp. 1123, 1138 (E.D. Cal. 1994); *Fulkerson v. Commissioners*, 802 F.Supp. 529, 536 (D.Me. 1992); and *Philadelphia Welfare Rights Org. v. O'Bannon*, 517 F.Supp. 501, 507 (E.D.Pa. 1981).

U.S.C. § 1396a(a)(30)(A), and that Ray Hanley and Roy Jeffus are entitled to qualified immunity from suit.

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IN THE

Supreme Court of the United States

JOHN SELIG, IN HIS OFFICIAL CAPACITY AS DIRECTOR OF THE ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Petitioners,

v.

PEDIATRIC SPECIALTY CARE, INC., ET AL.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF STATES AND STATE AGENCIES AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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The States and state Medicaid agencies listed below respectfully submit this brief of *amici curiae* in support of petitioners in this case.[1] Letters indicating the consent of parties to the filing of this brief have been filed with the Clerk.

INTEREST OF *AMICI CURIAE*

Amici curiae administer the joint federal-state program known as Medicaid, subject to oversight by the federal government. State Medicaid officials are regularly called on to interpret the federal Medicaid statute and regulations and to make policy decisions about how the program should be implemented.

Amici have a strong interest in this case. The court of appeals affirmed denial of summary judgment to Arkansas Medicaid officials who sought qualified immunity in connection with their implementation of a prior authorization program designed to control the use of certain medical services. As described below, if allowed to stand, the decision below will materially impede States' efforts to deal with the growing cost of the Medicaid program, threatening state officials with personal liability for implementing policies designed to control costs.

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[1] Pursuant to Rule 37.6, *amici* state that no counsel for any petitioner or respondent authored this brief in whole or in part. No person or entity, other than *amici*, their members, or their counsel, made a monetary contribution to the preparation or submission of this brief.

STATEMENT

Medicaid — the primary source of health care for the needy in the United States — is one of the largest and fastest growing programs of the federal government and of each of the States and territories. Managing that growth, and controlling its cost, is perhaps the most important–and difficult issue of public administration confronting state governments today. The decision below, if allowed to stand, will materially impede States' efforts to deal with this issue, threatening state officials with personal liability for implementing policies to control cost.

1. Medicaid is a joint federal-state program established in 1965 by Title XIX of the Social Security Act ("Act"), Pub. L. No. 89-97, 79 Stat. 343 (codified as amended at 42 U.S.C. §§ 1396 *et seq.* (2000 & Supp. III)). A State participates in Medicaid pursuant to a State Plan, approved by the Secretary of Health and Human Services, who has delegated this function to the Administrator of the Centers for Medicare & Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS). The State Plan establishes eligibility groups, the various services to be provided, and the reimbursement rates to be paid to the entities that provide those services. *See* 42 U.S.C. § 1396a (2000 & Supp. III); 42 C.F.R. § 430.10 (2005). States receive partial federal reimbursement for payments made for approved "medical assistance" under the State Plan. 42 U.S.C. § 1396b (2000 & Supp. III).

While each State is responsible for designing and administering its own Medicaid program, States must operate their programs in compliance with a multitude of federal statutory and regulatory guidelines. Among other things, a State Plan must "include reasonable standards . . . for determining . . . the extent of medical assistance;" it must provide safeguards to ensure that care and services are provided "in a manner consistent with simplicity of

administration and the best interests of the recipients;" and it must provide such methods and procedures "as may be necessary to safeguard against unnecessary utilization of such care and services" and to ensure that "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(17), (19), (30)(A) (2000 & Supp. III).

Most of the services that may be provided as medical assistance are expressly enumerated in the statute. *See* 42 U.S.C. § 1396d(a)(1)-(3) (2000 & Supp. III) (listing inpatient hospital services, outpatient hospital services, laboratory, and x-ray services). However, some categories of medical assistance are more nebulous in their scope. For example, Section 1905(a)(13) of the Act permits States to cover, at their option,

> other diagnostic, screening, preventive, and rehabilitative services . . . recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical and mental disability and restoration of an individual to the best possible functional level.

42 U.S.C. § 1396d(a)(13). Similarly broad language can be found in the requirement that individuals under the age of 21 receive "early and periodic screening, diagnostic and treatment services" — the so-called "EPSDT" benefit — including any service listed in the statute that is necessary "to correct or ameliorate defects and physical and mental illnesses and conditions discovered . . . whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(a)(4)(B), (r)(5). The broad wording of these two

provisions has been at issue in a number of recent decisions requiring States to provide children with services that are not expressly required or defined in the statute, the implementing regulations, or any other federal guidance to the States.[2]

2. The States' obligation to cover certain care and services under the Medicaid program is balanced by their authority and obligation to ensure that the scope of Medicaid expenditures is necessary and appropriate. States are authorized to conduct a "utilization review" to "safeguard against unnecessary utilization of such care and services." 42 U.S.C. § 1396a(a)(30)(A) (2000 & Supp. III). For each service provided, federal regulations give States flexibility to establish reasonable parameters, so long as each service is "sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b) (2005). State Medicaid agencies are encouraged to "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." *Id.* § 440.230(d).

This authority extends to EPSDT services as well. In its State Medicaid Manual (SMM), CMS gives States the "flexibility within the Federal Statutes and regulations to design an EPSDT program that meets the health needs of recipients." SMM ¶ 5010(C) (1990). CMS permits and also encourages the use of utilization control procedures for EPSDT services. *See* SMM ¶ 5122(F) (1994) ("[42 C.F.R. § 440.230] allows you to establish the amount, duration and scope of services provided under the EPSDT benefit.");

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[2] *See, e.g., S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 596 (5th Cir. 2004) (incontinence underwear); *Katie A. v. Bontá*, 433 F. Supp. 2d 1065, 1075 (C.D. Cal. 2006) ("therapeutic foster care"); *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 32 (D. Mass. 2006) (home-based supports for seriously emotionally disturbed children); *Collins v. Hamilton*, 231 F. Supp. 2d 840 849 (S.D. Ind. 2002) (residential psychiatric treatment); *Emily Q. v. Bontá*, 208 F. Supp. 2d 1078, 1090 (C.D. Cal. 2001) (therapeutic behavioral services).

SMM ¶ 5230.1(A) (1990) (States may cooperate with Maternal and Child Health programs to develop health services policies and standards for EPSDT, including assessments "with a view toward eliminating unnecessary services; duplication; providing acceptable quality of care, and integrating and providing all necessary services").

States may institute utilization controls by contracting with federally-certified peer review organizations, known as Quality Improvement Organizations (QIOs). 42 U.S.C. § 1396a(d) (2000 & Supp. III); 42 C.F.R. §§ 431.630, 456.2 (2005). QIOs review and approve requests for Medicaid services, before such services are provided, to determine whether they are medically necessary and "sufficient in amount, duration, and scope." 42 C.F.R. § 440.230(b) (2005). If a QIO physician denies the requested service, the recipient or provider can request reconsideration. 42 U.S.C. § 1320c-3(a)(3)(A)-(D) (2000 & Supp. III).

3. This case involves claims under 42 U.S.C. § 1983 brought against the Arkansas Department of Human Services (ADHS),[3] an ADHS contractor, and several ADHS officials who were sued in their individual, as well as official, capacities. The Fifth Amended Complaint, brought by providers of Child Health Management Services (CHMS) and several beneficiaries, alleged that changes made to the State's CHMS program violated the Medicaid statute.[4]

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[3] ADHS (now the Arkansas Department of Health and Human Services) administers the Medicaid program in Arkansas.

[4] CHMS is a multi-disciplinary program created by Arkansas that combines various therapies and early intervention day treatment for pre-school children who "have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions." *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472, 475 (8th Cir. 2002) (internal quotation mark omitted) (quoting Arkansas Medicaid Manual at II-19). The suit was in response to the State's attempt to eliminate the early intervention day treatment component from the state Medicaid Plan. Early intervention day treatment "is a type of day care (continued...)

Plaintiffs sought declaratory and injunctive relief and damages, including punitive damages.

In 2002, the Eighth Circuit affirmed a decision of the district court that "early intervention day treatment" was an EPSDT service that Arkansas was obligated to pay for under its Medicaid program. *Pediatric Specialty Care, Inc v. Ark. Dep't of Human Servs.*, 293 F.3d 472 (8th Cir. 2002). Thereafter, the plaintiffs challenged the "prior authorization" program ADHS had put in place to control utilization of the service.

In the decision below, the court of appeals considered the argument of two of the state officials — Ray Hanley and Roy Jeffus — that the district court erred in denying them qualified immunity from claims that they had violated rights under the Medicaid statute by implementation of the prior authorization process, which allegedly resulted in a reduction in the level of day treatment provided to children through CHMS. The court of appeals discussed at length the conduct of employees of Arkansas Foundation for Medical Care (AFMC), a QIO the State had engaged to administer the prior authorization process. *See* page 5, *supra*. Among other things, AFMC employees were alleged to have altered physician treatment recommendations and denied claims in order to reduce costs in an effort to obtain renewal of the contract.

The court of appeals concluded that under the Medicaid statute children had a clearly established right to receive the maximum level of treatment recommended by a provider physician and that reductions in day treatment resulting from use of the prior authorization process violated

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program run by early childhood specialists and overseen by medical staff. The curriculum is structured to ameliorate conditions discovered by the EPSDT evaluations and to strengthen the skills children learn in therapy." *Id.* at 476 n.2.

that right. *See* Pet. App. 13-19. While terming it a "difficult question," the court concluded that Hanley and Jeffus could be tied to the alleged wrongdoing of the AFMC employees. It stated that the officials "'implemented a policy [of prior authorization] that reduced the scope and duration of day treatment for beneficiaries of the Medicaid Act.'" Pet. App. 20 (alteration in original) (quoting Dist. Ct. Order of Feb. 7, 2005, at 38). According to the court, "Taking the evidence in the plaintiffs' favor, one could infer that [Hanley's and Jeffus'] primary motivation was to save money, although the statutes require them to act in the best interest of the needy children." Pet. App. 20. The court termed this "a violation of the rights clearly established under the §§ 1396d(a)(13) and 396a(a)(30)(A) [sic] and our prior case law" and affirmed the denial of the officials' summary judgment motions. Pet. App. 20.

SUMMARY OF ARGUMENT

The court of appeals' decision affirming denial of qualified immunity for two state Medicaid officials cannot be reconciled with this Court's decisions. The conclusion that use of a prior authorization program designed to control costs violated a clearly established right to Medicaid services is inconsistent with the statutory scheme and the legal standards articulated in this Court's qualified immunity decisions. The court of appeals adopted an unjustifiably expansive view of what constitutes a "clearly established right" under the Medicaid statute, embracing an interpretation that fails to give any weight either to the State's authority to establish the amount, duration, and scope of services that it will reimburse or to the federal policies favoring utilization controls. At a minimum, the alleged rights were not clearly established. Particularly when a plaintiff seeks to impose personal liability on a state official based on policy decisions implementing a complex federal-state program like

Medicaid, the "clearly established" test must be applied with care.

If the decision below is allowed to stand, it will cause serious practical problems for all States. State officials responsible for administering federal-state programs will face the threat of devastating personal financial liability when they implement policies designed to prevent misuse of state and federal funds. Even a remote prospect of such crippling liability will make it difficult for States to recruit qualified candidates for these positions. At a minimum, the decision will impede the efficient administration of the Medicaid program because state officials will be reluctant to institute utilization controls. In view of these serious practical consequences, the petition should be granted.

ARGUMENT

The undersigned States and state Medicaid agencies urge the Court to grant review to address a question of great significance to the States, concerning the availability of qualified immunity for state officials who administer federal-state programs. The court of appeals ventured into uncharted territory when it concluded that the alleged efforts of two Arkansas officials to control the cost of a service covered by the state Medicaid program may have violated a "clearly established right" to that service, depriving them of the protection of qualified immunity from suit. So far as *amici* are aware, the conclusion that a state policymaker may be personally liable under Section 1983 for implementing cost-control strategies is unprecedented.

If the decision below is allowed to stand, there will be serious practical consequences for States and for their ability to administer federal-state programs efficiently. This Court

should grant *certiorari* to correct the court of appeals' error and to prevent the significant harm that will follow if the decision is permitted to stand.[5]

I. The Court of Appeals Decided an Important Question Involving Qualified Immunity for State Officials in a Way That Cannot Be Reconciled with Decisions of This Court.

The court of appeals' conclusion that Arkansas Medicaid officials are not entitled to immunity from personal liability in connection with introduction of a prior authorization process departs from this Court's precedents. Because use of prior authorization review for Medicaid services did not violate any clearly established federal right, and in fact promotes the federal policy encouraging utilization controls for Medicaid, the state officials were entitled to qualified immunity.

A. To Ensure the Smooth Functioning of Government, Courts Must Grant Immunity to State Officials Whose Conduct Does Not Violate a Clearly Established Right.

Public officials who perform discretionary acts in good faith are entitled to qualified immunity from claims against them in their personal capacities under Section 1983. Such protection is needed "to shield [public officials] from

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[5] In addition to challenging the rejection of qualified immunity, the petition argues that the two provisions of the Medicaid statute on which the court of appeals relied — 42 U.S.C. § 1396a(a)(30)(A) (providing for utilization review and payment rates that permit access to services) and 42 U.S.C. § 1396d(a)(13) (defining "medical assistance" to include certain rehabilitative services) — do not create private rights enforceable under 42 U.S.C. § 1983. In concluding that these provisions create enforceable rights, the court failed to engage in the rigorous analysis of whether a statute includes "rights-creating" language required by this Court's recent precedents. *See Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002); *Blessing v. Freestone*, 520 U.S. 329 (1997).

undue interference with their duties and from potentially disabling threats of liability." *Harlow v. Fitzgerald*, 457 U.S. 800, 806 (1982).[6] As this Court has recently recognized, "The nub of qualified immunity is the need to induce officials to show reasonable initiative when the relevant law is not 'clearly established.'" *Will v. Hallock*, __ U.S. __, 126 S. Ct. 952, 960 (2006) (quoting *Harlow*, 457 U.S. at 818). Respect for state officials' initiative is particularly appropriate in the context of Medicaid, a federal-state partnership in which state officials must act as the responsible stewards of both federal and state funds in administering a program tasked with addressing the needs of many different groups with sometimes competing demands.

When ruling on a public official's summary judgment motion seeking qualified immunity, a court must determine first whether, taken in the light most favorable to the plaintiff, the facts alleged show that the official's discretionary conduct violated a federal constitutional or statutory right, taking into account the backdrop of law at the time of the conduct. *See Brosseau v. Haugen*, 543 U.S. 194, 197-98 (2004) (*per curiam*); *Saucier v. Katz*, 533 U.S. 194, 201 (2001). If the answer is affirmative, then "the next, sequential step is to ask whether the right was clearly established." *Saucier*, 533 U.S. at 201.

This Court has required lower courts to assess whether a right is clearly established "'in light of the specific context of the case, not as a broad general proposition.'" *Brosseau*, 543 U.S. at 198 (quoting *Saucier*, 533 U.S. at 201). An officer is entitled to qualified immunity even where

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[6] Qualified immunity is an immunity from suit, not merely a defense to liability. *See Mitchell v. Forsyth*, 472 U.S. 511, 526 (1985). This Court has held that "a district court's denial of a claim of qualified immunity, to the extent it turns on an issue of law, is an appealable 'final decision' within the meaning of 28 U.S.C. § 1291 notwithstanding the absence of a final judgment." *Id.* at 530.

she "reasonably misapprehends the law governing the circumstances she confronted." *Id.* Thus, qualified immunity protects public officials from the need to litigate claims against them in their personal capacity, except where federal law provided them with fair notice that their conduct was improper. *See id.* at 198-99.

B. The Conclusion That a Policy to Control Costs in the Medicaid Program Violated a Clearly Established Right to Medicaid Services Is at Odds With This Court's Guidance on Qualified Immunity.

The court below held that petitioners Hanley and Jeffus, who were responsible for administration of the Medicaid program in Arkansas, did not enjoy immunity from claims that they had violated the Medicaid statute. According to the court, the prior authorization program petitioners implemented resulted in a reduction in the amount of treatment provided to children, and, "[t]aking the evidence in the plaintiffs' favor, one could infer that [petitioners'] primary motivation was to save money, although the statutes require them to act in the best interest of the needy children." Pet. App. 20.[7] The court held that such conduct violated rights clearly established under §§ 1396d(a)(13) and 1396a(a)(30)(A).

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[7] The court cited ADHS "directives to AFMC about the extent of services that AFMC could approve." Pet. App. 20. However, it stopped short of suggesting that either Hanley or Jeffus was personally involved in issuing any such directives. It appears that there was only one "directive" issued by Hanley, and none by Jeffus. *See* Pet. App. 41. This "directive," an estimate of expected savings included in the initial notice of the prior authorization program, was simply the financial impact statement required for all rules promulgated under Ark. Code Ann. § 15-204(d)(1) and (d)(4) — hardly evidence that Hanley and Jeffus had a purpose of reducing payments to a pre-determined level, much less evidence of an intent to violate any federal right.

This conclusion is wrong in every respect. It is plainly inconsistent with this Court's decisions because institution of utilization controls — an act expressly permitted by statute — with the motivation to save money cannot possibly be a violation of a clearly established right. Moreover, the court of appeals' holding disregards the reality that state officials have an obligation to be responsible guardians of the state and federal funds that support Medicaid services. Implementation of utilization controls to achieve cost savings is not only lawful, it is key to efficient use of public funds.

1. There Is No Federal Right, Much Less a Clearly Established One, to Medicaid Services Free of Prior Authorization.

There is no right under the Medicaid statute to receive Medicaid services free from a prior authorization process. In fact, the sentence containing one of the provisions cited by the court of appeals — the so-called equal access provision[8] — also requires State Plans to include "such methods and procedures relating to the utilization of . . . care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services. . . ." 42 U.S.C. § 1396a(a)(30)(A) (2000 & Supp. III); *see also* 42 C.F.R. §§ 440.230(d), 456.3(a) (2005).

Federal law permits prior authorization as a form of utilization control. Indeed, federal regulations specifically provide for prior authorization in connection with services provided in hospitals, mental hospitals, and intermediate care

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[8] This provision requires that payments to providers be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A) (2000 & Supp. III).

facilities. *See* 42 C.F.R. §§ 456.60(a), 456.160(a), 456.360(a) (200 The Act rewards peer-review arrangements, inc ng those involving prior authorization, by providing enhanced federal matching to States that contract with private QIOs for this purpose. 42 U.S.C. § 1320c-7(b) (2000). CMS has encouraged prior authorization procedures for EPSDT services. *See* SMM ¶ 5230.1(A) (1990) (States may develop EPSDT assessments "with a view toward . . . eliminating unnecessary services").[9]

Far from being unlawful, the motivation of containing costs is an entirely appropriate (indeed, laudable) reason for a State to implement a prior authorization process. Prior authorization has the potential to achieve cost savings by screening out medically unnecessary services. There is no tension between a cost-saving motive and ensuring that medically necessary services are available to Medicaid-eligible children to the same extent they are available to the general population. *See* 42 U.S.C. § 1396a(a)(30)(A) (2000 & Supp. III).[10] A plurality of this Court has noted, in the context of a prescription drug prior authorization

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[9] Indeed, federal agencies have counseled States against provision of overly expansive Medicaid rehabilitative services for children. In 2000, an HHS publication advised that rehabilitative services, in general, are not available for the long term treatment of people with only developmental delays. *See* U.S. Dep't of Health & Human Services, *Understanding Medicaid Home and Community Services: A Primer* 11 (2000). More recently, the Government Accountability Office expressed concern that States may be classifying as "rehabilitative," and claiming under Medicaid, services for children that are actually the responsibility of other state agencies. U.S. Government Accountability Office, *Medicaid: States' Efforts To Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight* 18-19 (June 28, 2005).

[10] While the EPSDT benefit at issue in this case is expansive, it is limited to medically necessary services. *See* 42 U.S.C. § 1396d(r)(5) (2000 & Supp. III) (defining EPSDT benefit as encompassing "*necessary* health care, diagnostic services, treatment, and other measures") (emphasis added). The goal of prior authorization is to achieve accuracy in determining medical necessity.

requirement, that "[a]voiding unnecessary costs in the administration of a State's Medicaid program" is a valid "Medicaid purpose" for the policy, and that a State's decision to implement prior authorization (even when motivated by a state policy unrelated to the Medicaid statute) should be viewed in light of the "'considerable latitude' that characterizes optional participation in a jointly financed benefit program." *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 663-64, 666 (2003) (quoting *King v. Smith*, 392 U.S. 309, 318 (1968)); *see also id.* at 676 (Thomas, J., concurring in the judgment) (concluding that the Act gives States "broad discretion to impose prior authorization"); *cf. id.* at 685 (O'Connor, J., concurring in part and dissenting in part) (a State "may impose prior authorization to reduce Medicaid costs"). Lower courts have reached similar conclusions. *See Pharm. Research & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 825-26 (D.C. Cir. 2004); *Grier v. Goetz*, 402 F. Supp. 2d 876, 905-06 (M.D. Tenn. 2005).

The court of appeals found it significant that the prior authorization process had resulted in a reduction in the amount of day treatment authorized for children, noting that the process "essentially led to a wholesale reduction in CHMS services from six hours per day, per child to no more than three and one-half to four hours per day, per child." Pet. App. 6. However, the statute does not entitle Medicaid recipients to any particular quantity of services. Services such as CHMS are intended for "the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." 42 U.S.C. § 1396d(a)(13) (2000 & Supp. III). But this does not mean that the level of services a provider recommends cannot be reduced if an independent reviewer concludes that a portion of those services is not medically necessary.

The court of appeals asserted that its earlier decisions in this litigation clearly established the alleged rights. *See*

Pet. App. 15. But these decisions focused on different aspects of Arkansas' administration of Medicaid rehabilitative services for children; neither decision even discussed the prior authorization process. *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993), also cited by the court of appeals (Pet. App. 15), likewise did not involve a prior authorization process or appropriate means for evaluating medical necessity. The court there held only that, before implementing a rate reduction for services, a State must consider the factors listed in 42 U.S.C. § 1396a(a)(30)(A).[11] In any event, the authority cited earlier in this section makes clear that the rights alleged by plaintiffs were not clearly established.[12]

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[11] 6 F.3d at 529-30. The court of appeals also cited the deposition testimony of a psychologist for the proposition that children do better with more hours of treatment. *See* Pet. App. 6. This is not evidence that the alleged right to six hours of day treatment is clearly established.

[12] The court of appeals may have concluded that it could impute to petitioners the conduct of employees of AFMC, the contractor charged with administering the prior authorization process. Such imputation would be improper. The court did not suggest that Hanley and Jeffus personally participated in any of the alleged AFMC wrongdoing (*e.g.*, unauthorized revision of physician recommendations). Nor did the court cite anything in the AFMC contract that conflicted with the statute.

This Court has made clear that vicarious liability may not be imposed under Section 1983. *See Monell v. Dep't of Soc. Servs.*, 436 U.S. 658, 694 (1978); *see also id.* ("[A] local government may not be sued under § 1983 for an injury inflicted solely by its employees or agents"). This Court has not considered vicarious liability in connection with a claim against an individual public official. However, courts of appeals have rejected vicarious liability for officials sued in their individual capacity. *See, e.g., McQueen v. Beecher Cmty. Schs.*, 433 F.3d 460, 470 (6th Cir. 2006); *Evett v. DETNFF*, 330 F.3d 681, 689 (5th Cir. 2003).

2. The "Clearly Established" Test Must Be Applied With Care When Reviewing the Actions of State Officials Who Must Implement the Broad Mandates of the Medicaid Statute.

Even if there were a statutory right to receive particular Medicaid services free from a prior authorization process motivated by cost containment concerns, or a right to receive six (rather than four) hours of treatment per day, such a right certainly was not obvious. The court below departed from this Court's precedents when it held that such a right was clearly established.

In *Brosseau*, this Court instructed that broadly-worded precedents do not ordinarily provide public officials with fair notice that particular conduct is unlawful, warranting a denial of qualified immunity. 543 U.S. at 199. A prior decision holding that a police officer's use of excessive force violates the Fourth Amendment, for example, does not "clearly establish" that an officer is unjustified in shooting a disturbed suspect fleeing in a vehicle. *Id.* Instead, this Court in *Brosseau* reviewed other authority and determined that there was no consensus that that particular conduct constituted excessive force. *Id.* at 200-01. While there is no bright-line rule that the exact conduct at issue must have been held unlawful in a previous decision, the Court has explained that the unlawfulness of an action must be "'apparent'" in order to warrant denial of qualified immunity. *Hope v. Pelzer*, 536 U.S. 730, 739 (2002) (quoting *Anderson v. Creighton*, 483 U.S. 635, 640 (1987)).

The court of appeals disregarded these holdings, announcing in a conclusory manner that a prior authorization policy motivated by cost-saving concerns violates rights clearly established by the Medicaid statute. Pet. App. 20. The court defined the statutory obligation at issue as

"act[ing] in the best interest of the needy children." *Id.* Such an abstractly defined obligation cannot reasonably alert State Medicaid Directors that a specific policy is unlawful.

A careful analysis of whether an alleged right is "clearly established" is particularly important in a case involving state policymakers. This Court has rarely addressed qualified immunity for a state or local policymaker, and has never addressed the qualified immunity of a state policymaker responsible for implementing a federal-state program that confers significant autonomy on the State.[13] In this setting, the chief concern behind qualified immunity — encouraging state officials to tackle difficult problems — operates with particular force.

In fact, the decision below might be best described as an end-run around the constitutional limitations on suits against States. Unlike a case involving shooting of a suspect, this suit is essentially an attack on a state policy, rather than the individual action of a particular state official. As the court of appeals recognized, the Eleventh Amendment limits any action against Arkansas or its agencies to a suit against state officials in their official capacities for prospective injunctive relief, to force a change in the state policy. *See* Pet. App. 21. Retrospective relief, such as damages, against the State (or its officials when sued in their official capacity) is prohibited.[14] Plaintiffs' effort to recover damages from the

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[13] Only one recorded federal court decision has examined a state policymaker's qualified immunity for Medicaid decisions. In *Bethany Medical Center v. Harder*, 693 F. Supp. 968 (D. Kan. 1988), a district court granted qualified immunity to a state official who had allegedly failed to implement certain supplemental Medicaid payments for hospitals, despite a statutory command to do so. Emphasizing the flexibility accorded to state Medicaid programs in interpreting and implementing the governing federal statutes, the court held that there was no violation of clearly established federal law. *Id.* at 979-81.

[14] *See, e.g., Frew v. Hawkins*, 540 U.S. 431, 437 (2004); *Edelman v. Jordan*, 415 U.S. 651, 668 (1974).

individual state policymakers, in amounts that would clearly be beyond the capacity of public officials to bear, should be seen as an effort to obtain through the back door a form of relief against the State that the Constitution prohibits.

II. If Not Reversed, the Decision Below Will Cause Severe Practical Problems for the States.

Unless this Court grants *certiorari* and reverses, the decision below will cause severe problems for States and for state officials charged with administering federal-state grant programs. As a result of the denial of qualified immunity, state officials responsible for administering the Medicaid program will be subject to a trial and will face potential personal liability for millions of dollars in damages based on their effort to control costs for one narrow category of services. Other state officials within the Eighth Circuit will be aware that they, too, may face a similar threat of personal liability if they institute utilization controls in an effort to control the inexorable increases in Medicaid spending. (Nothing in the decision suggests that its reasoning is limited to day treatment services.) State officials everywhere will be aware that other circuits may follow this precedent.

Even a remote threat of such massive personal liability may well dissuade qualified professionals from public service. States need expert administrators to handle the many large and complex federal-state programs that provide services to millions of residents. Medicaid, one of the largest of these programs, "gives each state flexibility in designing and administering its own Medicaid program." *La. Dep't of Health & Hosps. v. Ctr. for Medicare & Medicaid Servs.*, 346 F.3d 571, 572 (5th Cir. 2003). Each policy decision requires state officials to interpret complex federal laws and regulations, and reasonable minds can differ regarding what is required. It will be difficult for States to recruit candidates to administer such programs with the threat

of massive damages looming in connection with efforts to demonstrate fiscal responsibility.

In addition to making it difficult for States to recruit for policymaking positions, this precedent is almost certain to discourage state officials from introducing utilization controls or other cost-control measures. For years, Congress and federal officials have expressed concern about waste in federal programs, including spiraling costs in the Medicaid program, and have encouraged state officials to take steps to assure that expenditures of federal funds are prudent. The decision below creates just the opposite incentive.

CONCLUSION

The petition for a writ of *certiorari* should be granted.

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